

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG210 2-11-57 et

01924

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1931

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home				d. STREET ADDRESS 12211 Connecticut Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Esther Middle Abrams Last Abrams				4. DATE OF DEATH Month Feb. Day 1 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 1, 1888	
9. AGE (In years last birthday) yrs. 69		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Jacob Cantor				14. MOTHER'S MAIDEN NAME Sarah			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. George Pikser Address Daughter	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Coronary Occlusion 420.1 DUE TO Coronary Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) unknown DUE TO (c) unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) myocardial Infarction - convalescent							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 11/3 , 19 56 , to 2/1 , 19 57 , that I last saw the deceased alive on 1/25 , 19 57 , and that death occurred at 1 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3900 McKinley St. N.W. DATE SIGNED 2/1/57 ACTUAL SIGNATURE Irving W. Winik M.D. Washington 15, D.C. PHYSICIAN'S NAME (Type) Irving W. Winik							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/1/57		22c. NAME OF CEMETERY OR CREMATORY National Capitol Hebrew		22d. LOCATION (City, town, or county) (State) Wash., D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons 3501 14th St., N. W.				24a. REC'D BY REGISTRAR DATE 2-2-57		24b. REGISTRAR'S SIGNATURE Benjamin M. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 21 Film G211 2-25-57 et

1932

CERTIFICATE OF DEATH

01925

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>67 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Albert</u> Last <u>Arnold</u>				4. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7 December 1897</u>	9. AGE (In years lost birthday) yrs. <u>59</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assistant Foreman</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assistant Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Berton Arnold</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Horner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Not available</u>		17. INFORMANT Address <u>The Medical Record, Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Esophagus</u> <u>150X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County)		
					(State)		
21. I certify that I attended the deceased from <u>December 12, 19 57</u> to <u>February 17, 19 57</u> , that I last saw the deceased alive on <u>February 17, 19 57</u> , and that death occurred at <u>3.50 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard R. Engel</u>				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Howard R. Engel, M.D.</u>				DATE SIGNED <u>2/17/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 20, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Mountcastle</u>				24a. REC'D BY REGISTRAR DATE <u>2-20-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		FEB 21 1957		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
1234 5th Ave		Teacher		Heart Disease		Natural		12345		Yes	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		HISTORY	
JAN 15 1912		NEW YORK		High School		Married		None		None	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S RESIDENCE		MOTHER'S RESIDENCE	
John H. Harris		Mary H. Harris		Farmer		Homemaker		1234 5th Ave		1234 5th Ave	
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S RACE		MOTHER'S RACE	
JAN 15 1880		JAN 15 1885		NEW YORK		NEW YORK		W		W	
FATHER'S MARRIAGE		MOTHER'S MARRIAGE		FATHER'S PREVIOUS ILLNESS		MOTHER'S PREVIOUS ILLNESS		FATHER'S HISTORY		MOTHER'S HISTORY	
Married		Married		None		None		None		None	
FATHER'S DEATH		MOTHER'S DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH	
None		None		None		None		None		None	
FATHER'S CERTIFICATE NO.		MOTHER'S CERTIFICATE NO.		FATHER'S REGISTERED		MOTHER'S REGISTERED		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH	
None		None		Yes		Yes		None		None	

RECEIVED
BUREAU V. S.
 FEB 21 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 210 2-11-57 et

1933

CERTIFICATE OF DEATH

Reg. Dist. No.

11926
276

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN IB <u>7 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. STREET ADDRESS <u>914 Maple Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>EDWARD</u> Last <u>AYERS, Sr.</u>				4. DATE OF DEATH Month <u>2</u> Day <u>2</u> Year <u>1954</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2 April 1884</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Bedford County, Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Thomas J. Ayers</u>				14. MOTHER'S MAIDEN NAME <u>Ninna Ashwell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>none</u>				16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Walter E. Ayers, Jr. - Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>42</u> (b) <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. p.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>31 Jan</u> , 19 <u>57</u> , to <u>42 Feb</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2 Feb</u> , 19 <u>57</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7 Crothers Court, Rock. Md</u> DATE SIGNED <u>2/2/57</u>							
ACTUAL SIGNATURE <u>Herman C. Maganzini</u> M.D. <u>7 Crothers Court, Rock. Md</u>							
PHYSICIAN'S NAME (Type) <u>Herman C. Maganzini</u> <u>7 Crothers Ct Rockville, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 5, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Roanoke, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. D. Kumphey - Bethesda - Beth. Md.</u>				ADDRESS <u>Beth. Md.</u>		24a. REC'D BY REGISTRAR <u>2-5-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1934

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH <u>Kensington Gardens</u> a. COUNTY <u>Montgomery</u> <u>Kensington</u> , MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D. C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b <u>10 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Nursing Home</u>				d. STREET ADDRESS <u>5 Pinehurst Circle, N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>J.</u> Last <u>Bailey</u>				4. DATE OF DEATH Month <u>February</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 19, 1878</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>78</u> Days <u>78</u> Hours <u>78</u> Min. <u>78</u>		IF UNDER 24 HRS. Months <u>78</u> Days <u>78</u> Hours <u>78</u> Min. <u>78</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>	
13. FATHER'S NAME <u>Albert H. Bailey</u>				14. MOTHER'S MAIDEN NAME <u>Adele Buchanan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Gilman Bailey-5 Pinehurst Circle Chevy Chase, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia (Terminal)</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular-renal Disease</u> DUE TO <u>Total paralysis, left leg and left arm</u> (c) <u>7 years</u> <u>7 years</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>April 1, 1954</u> to <u>Feb. 26, 1957</u> , that I last saw the deceased alive on <u>Feb. 26, 1957</u> , and that death occurred at <u>5 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ed A. Krause</u>				M.D. <u>3805 McKinley St., N.W.</u> <u>2/26/57</u> <u>Washington 15, D. C.</u>			
PHYSICIAN'S NAME (Type) <u>Edward A. Krause</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>2/28/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. Washington, D. C.</u>				ADDRESS <u>Washington, D. C.</u>		24a. REC'D BY REGISTRAR <u>Francis Pattery</u>	
				24b. REGISTRAR'S SIGNATURE <u>Francis Pattery</u>		DATE <u>FEB 28 1957</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		M		W		12-1-28		MOBILE, ALA.		4-4-68		MOBILE, ALA.	
MARRIED		SINGLE		MARRIED		SINGLE		MARRIED		SINGLE		MARRIED		SINGLE	
EDUCATION		HIGHER		HIGHER		HIGHER		HIGHER		HIGHER		HIGHER		HIGHER	
OCCUPATION		BUSINESS		BUSINESS		BUSINESS		BUSINESS		BUSINESS		BUSINESS		BUSINESS	
CAUSE OF DEATH		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE	
MANNER OF DEATH		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL	
SIGNATURE OF PHYSICIAN		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF CORONER		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF DEATH REGISTRAR		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF WITNESS		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF DECEASED		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. 3

FEB 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1935 CERTIFICATE OF DEATH

01928

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 3 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS Qtrs. "B", Navy Gun Factory	
3. NAME OF DECEASED (Type or print) First Josebio Middle Mundo Last BAINCO		4. DATE OF DEATH Month February Day 10 Year 19 57	
5. SEX Male	6. COLOR OR RACE Malayan	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 Feb. 1957
9. AGE (In years lost birthday) yrs. 3		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 3 Days 3 Hours 3 Min. 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nonen		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Eusebio (n) Bainco		14. MOTHER'S MAIDEN NAME Josefina Mundo	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Eusebio Bainco (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CON GENITAL ATE LEC TASIS DUE TO 762.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PRE MAT URITY DUE TO (c) 72 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 9 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 Feb. , 19 57 , to 10 Feb. , 19 57 , that I last saw the deceased alive on 10 Feb. , 19 57 , and that death occurred at 1:45 A. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Daniel Shuptar		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 2-11-57	
PHYSICIAN'S NAME (Type) Daniel Shuptar, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-12-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey		24a. REC'D BY REGISTRAR DATE 2-11-57	
24b. REGISTRAR'S SIGNATURE Mary E. Russell		24c. ADDRESS 5557 Wisconsin Ave., Bethesda, Md.	

2051261XY2

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

BUREAU V. S.

FEB. 13. 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1938 CERTIFICATE OF DEATH

Reg. Dist. No.

01929
215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Erwin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 80 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Andrew Middle (nmn) Last BANYAS		4. DATE OF DEATH Month February Day 19 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 5, 1934
9. AGE (In years lost birthday) 22 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Andrew Banyas		14. MOTHER'S MAIDEN NAME Elsie Drango	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Mother) Mrs. Elsie R. Schwerha (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Seminoma of right testis with 178x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastases to regional nodes and abdominal DUE TO (c) and thoracic viscera. INTERVAL BETWEEN ONSET AND DEATH 8-12 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. 7. Month, Day, Year 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 Dec. , 19 56 , to 19 Feb. , 19 57 , that I last saw the deceased alive on 19 Feb. , 19 57 , and that death occurred at 7:55A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 2-19-57			
ACTUAL SIGNATURE Byron D. Casteel		M.D. U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) BYRON D. CASTEEL, CAPT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-23-57	
22c. NAME OF CEMETERY OR CREMATORY Braddock Catholic Cemetery		22d. LOCATION (City, town, or county) (State) Braddock, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey		ADDRESS 7557 Wisconsin Ave., Bethesda, Md.	
24a. REC'D BY REGISTRAR 2-20-57		24b. REGISTRAR'S SIGNATURE Mary E. Casella	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BUREAU OF VITAL RECORDS

RECEIVED
BUREAU V. 3
 FEB 25 1957

CERTIFICATE OF DEATH

01930

Reg. Dist. No.

223

1910

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>16 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>Briggs-Chaney Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Eugenia</u> Last <u>Barker</u>				4. DATE OF DEATH Month <u>2</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 8 - 1873</u>	
9. AGE (In years last birthday) <u>82 yrs.</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>13</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Music teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed-ret</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles Porter</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Boatwright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>8. lateral/ Common iliac Embolism, Atherosclerotic</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>August</u> <u>1955</u> , to <u>Feb. 21</u> <u>1957</u> , that I last saw the deceased alive on <u>Feb 21</u> <u>1957</u> , and that death occurred at <u>6:50 P.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>J. M. Whitlock</u> M.D. <u>7600 Carroll Ave. Takoma P, Md - 22-57</u>							
PHYSICIAN'S NAME (Type) <u>J. M. Whitlock, M.D.</u>				<u>7600 Carroll Avenue, Takoma Park, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>		22b. DATE THEREOF <u>2/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cem. Inc.</u>		22d. LOCATION (City, town, or county) (State) <u>Sullivan Co. (Bristol) Tennessee</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert D. Conroy</u> ADDRESS <u>7557 Wis. Ave. Bethesda, Md</u>				24a. REC'D BY REGISTRAR <u>Feb 23 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. M. Whitlock</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

XXXXXXXXXXXX Silver Spring
Bridges-Cannoy Road

of-employed-for Virginia

Unknown

BUREAU V. S.

FEB 27 1957

RECEIVED

701 11 Ave. Bethesda, Md

Clenwood Corp., Inc.

J. M. Whitlock, M.D.

7000 Carroll Ave., Takoma

1937 CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b <u>9-8-56-2-11-57</u> <u>X2</u> <u>Kensington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington GARDENS SANTARIUM</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>EMMA</u> Last <u>Bastable</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 22 - 1872</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>York, Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Gilbert Leber</u>			
14. MOTHER'S MAIDEN NAME <u>Emma B. Bubaker</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>--</u> (If yes, give war or dates of service) <u>--</u>			
16. SOCIAL SECURITY NO. <u>--</u>				17. INFORMANT <u>G. C. Kindig- 11604 Viers Mill Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerotic Cardio-vascular disease</u> years DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>Jan.</u> _____, 19 <u>54</u> , to <u>Feb 11</u> _____, 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 10</u> _____, 19 <u>57</u> , and that death occurred at <u>8:30AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Russell M. Tilley, Jr.</u> M.D. <u>4701 - Mass. Ave. N.W.</u> <u>2-11-57</u>				ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
PHYSICIAN'S NAME (Type) <u>Russell M. Tilley, Jr.</u> <u>Wash. 16, D.C.</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>2/14/57</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. S. H. Niner Co.</u> ADDRESS <u>2801-14th St. N.W.</u> <u>Washington D.C.</u>			
24a. REC'D BY REGISTRAR <u>DATE 2/14/57</u>				24b. REGISTRAR'S SIGNATURE <u>Mrs. Frances Potter</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

BUREAU V. 3

1957 1-1-1957

RECEIVED

1938 CERTIFICATE OF DEATH

Reg. Dist. No. *216*

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 81 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Robert Frederick Batchelor				4. DATE OF DEATH February 25, 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 24, 1920	
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Veterinarian		10b. KIND OF BUSINESS OR INDUSTRY Food & Drug (Gov't)		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred Batchelor				14. MOTHER'S MAIDEN NAME Jeanette Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 284-16-4726		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkins Disease with involvement of lungs, spleen and lymph nodes. 201x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from December 6, 19 56 , to February 25, 19 57 , that I last saw the deceased alive on February 25, 19 57 , and that death occurred at 3:45 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James R. Stabenau M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) James R. Stabenau, M.D.				DATE SIGNED 2/25/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removed		22b. DATE THEREOF Feb 27, 1957		22c. NAME OF CEMETERY OR CREMATORY Isleido, Ohio		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE C.P. Issa, mrs. Arlington 1, Va.				24a. REC'D BY REGISTRAR 2-27-57		24b. REGISTRAR'S SIGNATURE Beane M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

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RECEIVED

MAR 1 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01933

1939 CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>9810 Georgia Ave.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4718-3 Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maple Lane Rest Home -9810 Ga. Ave.</u>		d. STREET ADDRESS <u>2926 Cortland Place N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>H.</u> Last <u>BATES</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/11/81</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Government Printing Office</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Thomas A. Bates</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bates</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Flossie Bates-2926 Cortland Place N.W.</u>		Address <u>Washington, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDITIS</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>PARALYSIS AGITANS</u> DUE TO (c) <u>CHRONIC MYOCARDITIS</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC PROSTATITIS</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. 1.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>JAN. 5</u> , 19 <u>57</u> , to <u>FEB. 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>FEB. 9</u> , 19 <u>57</u> , and that death occurred at <u>8:12 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry M. Lowden</u> M.D.		ADDRESS (Street, city or town, state) <u>5206 Norwary Dr. Chevy Chase, Md.</u>	
PHYSICIAN'S NAME (Type) <u>HENRY M. LOWDEN M.D.</u>		DATE SIGNED <u>2/9/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>2/12/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Company</u>		ADDRESS <u>Washington, D.C.</u>	
24a. REC'D BY REGISTRAR <u>FEB 21 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

BUREAU V. S.

FEB 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01934

1940 CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Browningsville		c. LENGTH OF STAY IN 1b years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. Monrovia		e. STREET ADDRESS 1 R.F.D. Monrovia	
3. NAME OF DECEASED (Type or print) First Louis Middle Imogene Last Beall		4. DATE OF DEATH Month February Day 4 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1876
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Kempton, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Poole		14. MOTHER'S MAIDEN NAME Mary M. Buxton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Virgie B. Beall, Monrovia, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10, 1953 to February 4, 1957 , that I last saw the deceased alive on February 2, 1957 , and that death occurred at 5:00 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE James P. Kerr		ADDRESS (Street, city or town, state) Damascus, Md.	
PHYSICIAN'S NAME (Type) James P. Kerr		DATE SIGNED 2/5/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 6, 1957	
22c. NAME OF CEMETERY OR CREMATORY Bethesda Methodist		22d. LOCATION (City, town, or county) (State) Browningsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas L. Molesworth		ADDRESS Damascus, Md.	
24a. REC'D BY REGISTRAR Feb. 5/57		24b. REGISTRAR'S SIGNATURE Lella W. Burdett	

RECEIVED

FEB 8 1957

1911

CERTIFICATE OF DEATH

Reg. Dist. No.

773

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN lb <u>22 months</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Springs</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>			d. STREET ADDRESS <u>1712 Wayne ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lucinda</u> Middle <u>Lilley</u> Last <u>Beck</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>27</u> Year <u>19 57</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-1-69</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			13. FATHER'S NAME <u>John Schissler</u>		
14. MOTHER'S MAIDEN NAME <u>Anna Lilley</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Son in law - chart. (same)</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>443X Hypertensive hypertrophy heart</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1, 1957</u> to <u>Feb 27, 1957</u> that I last saw the deceased alive on <u>Feb 27, 1957</u> , and that death occurred at <u>2:50 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7701 Canallane</u> DATE SIGNED <u>2-27-57</u>					
ACTUAL SIGNATURE <u>J. M. Whitlock</u>		M.D. <u>Takoma Park, Md.</u>			
PHYSICIAN'S NAME (Type) <u>J.M. Whitlock</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/1/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Mausoleum</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thos. A. Vines Co.</u>		ADDRESS <u>2901-14th St. W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u> </u>	24b. REGISTRAR'S SIGNATURE <u>J. Wilson Duddy</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page J should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

BUREAU V. 3

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01936

1941

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 29 days					
d. NAME OF HOSPITAL (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Theresa Ann BERGTHOLD				4. DATE OF DEATH Month Day Year February 6 1957					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 July 1956			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None					
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME John I. Bergthold				14. MOTHER'S MAIDEN NAME Barbara J. Myers					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None					
17. INFORMANT (Mother) Barbara J. Bergthold (Same As #2)				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.4 Congenital Heart Disease (Transposition great vessels) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 6 mo 20 da. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8 January , 19 57 , to 6 February , 19 57 , that I last saw the deceased alive on 6 February , 19 57 , and that death occurred at 4:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 2-7-57									
ACTUAL SIGNATURE James E. Mc Clenathan				U.S.N.				DATE SIGNED 2-7-57	
PHYSICIAN'S NAME (Type) James E. Mc Clenathan, LCDR, MC, U.S. Naval Hospital, Bethesda, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12 Feb. 1957		22c. NAME OF CEMETERY OR CREMATORY Private Cemetery		22d. LOCATION (City, town, or county) (State) Pittsfield, Illinois			
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey				24a. REC'D BY REGISTRAR 2-7-57		24b. REGISTRAR'S SIGNATURE May E. Russell			

RECEIVED

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coupon papers. Pages 7 and 8 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1942 CERTIFICATE OF DEATH

01937

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10902 Kenilworth Ave. X2 Garrett Park			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Norbeck				c. LENGTH OF STAY IN 1b 2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Philomena				d. STREET ADDRESS 10902 Kenilworth Avenue			
3. NAME OF DECEASED (Type or print) JOHN R. BIRD				4. DATE OF DEATH Feb. 10, 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 9, 1875	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 10 Days 1		IF UNDER 24 HRS. Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinest (retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Norwich, Conn	
13. FATHER'S NAME Joseph Bird				14. MOTHER'S MAIDEN NAME Susan Clay			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Edward F. Cassidy Address Garrett Park 10911 Stillwater Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from January, 1955 , to Feb 8, 1957 , that I last saw the deceased alive on February 8, 1957 , and that death occurred at 8:20 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Morton C. Creditor				ADDRESS (Street, city or town, state) WASHINGTON CLINIC			
PHYSICIAN'S NAME (Type) Dr. Morton C. Creditor				DATE SIGNED Washington 15, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/10/57		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Prince George Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland				24a. REC'D BY REGISTRAR 2/12/57		24b. REGISTRAR'S SIGNATURE Robert B. Lawler	

715

BUREAU V

FEB 20 1957

RECEIVED

1912

CERTIFICATE OF DEATH

Reg. Dist. No. 2 23

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>47X-3</u> b. COUNTY <u>WASHINGTON, D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. SAN. & HOSP.</u>				e. STREET ADDRESS <u>6313-16th ST NW.</u>			
3. NAME OF DECEASED (Type or print) <u>BENJAMIN M. BODNICK</u>				4. DATE OF DEATH <u>FEB. 19-1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY-1-1892</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. MERCHANT PAUNBROKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RUSSIA</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>ISAAC BODNICK</u>				14. MOTHER'S MAIDEN NAME <u>GOLDA BELA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>579-01-1260</u>			
17. INFORMANT <u>TILLIE BODNICK</u>				Address <u>6313-16th NW.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive Heart Failure</u> DUE TO (b) <u>Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>3 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>56</u> , to <u>Feb. 19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb. 18</u> , 19 <u>56</u> , and that death occurred at <u>7:50 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel Dessoff</u>				ADDRESS (Street, city or town, state) <u>1302-18th St NW Wash 6, D.C.</u>			
PHYSICIAN'S NAME (Type) <u>SAMUEL DESSOFF</u>				DATE SIGNED <u>2/19/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nat'l Cap Hebrew Cem</u>		22d. LOCATION (City, town, or county) <u>Cap Hts Md</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goodberg funeral home</u>				ADDRESS <u>4217-9th NW</u>		24a. REC'D BY REGISTRAR <u>2/21/57</u>	
24b. REGISTRAR'S SIGNATURE <u>J. Miller Dodd</u>				DATE _____			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
MARRIED		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF BIRTH		DATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		DATE	

BUREAU V. S.

FEB 25 1957

RECEIVED

1943

CERTIFICATE OF DEATH

01939

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>SOUTH DAKOTA</u> b. COUNTY <u>MINER</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>28hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>Howard, 78X-3</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>OSCAR</u> Middle <u>John</u> Last <u>Boos</u>				4. DATE OF DEATH Month <u>2</u> - Day <u>8</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-8-84</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BANKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (State or foreign country) <u>IOWA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>VALENTINE Boos</u>				14. MOTHER'S MAIDEN NAME <u>CHRISTINA? Boos</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Jessie (wife) Howard, South Dakota</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHITIS PNEUMONIA, TERMINAL</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>420</u> (b) <u>Cerebral thrombosis, R. M. D. Cerebral artery</u> DUE TO <u>Cerebral Arteriosclerosis</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>48 hrs</u> <u>5 YRS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>DEC 24</u> , 19 <u>56</u> to <u>FEB 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>FEB 8</u> , 19 <u>57</u> , and that death occurred at <u>11:30</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert G. Angle</u> M.D.				ADDRESS (Street, city or town, state) <u>Bethesda, Md.</u> DATE SIGNED <u>February 8, 1957</u>			
PHYSICIAN'S NAME (Type) <u>Robert G. Angle, M.D.</u>				5009 Del Ray Avenue, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>				22b. DATE THEREOF <u>2/9/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wyuka (via Howard, S. Dak.)</u>	
22d. LOCATION (City, town, or county) <u>Lancaster Co.</u>				(State) <u>Nebraska</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.</u>				ADDRESS <u></u>		24a. REC'D BY REGISTRAR <u>2-8-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1913

CERTIFICATE OF DEATH

01940

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				d. STREET ADDRESS <u>7626 Normandy Road</u>			
3. NAME OF DECEASED (Type or print) <u>Charles William Lee Bower</u>				4. DATE OF DEATH <u>February 27 1957</u>			
5. SEX <u>Boy</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 25, 1957</u>	
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Randolph Bower</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Alice Belland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mother - Eleanor Bower - Palmer Park, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemolytic disease of newborn.</u> <u>770.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity.</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Feb. 25</u> , 1957, to <u>Feb. 27</u> , 1957, that I last saw the deceased alive on <u>Feb. 27 - 57</u> , 1957, and that death occurred at <u>6:52 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ruth Slantford</u>				ADDRESS (Street, city or town, state) <u>M.D. Wash. San + Hosp. Takoma Park Md.</u>			
PHYSICIAN'S NAME (Type) <u>—</u>				DATE SIGNED <u>2-27-57</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR. 1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WHEATON, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hyson</u>				ADDRESS <u>1300-N St NW - Wash DC</u>		24. REC'D BY REGISTRAR <u>—</u>	
25. REGISTRAR'S SIGNATURE <u>J. Thompson</u>				DATE <u>28 1957</u>		26. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

FEB 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01941

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16-15-2 Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center</u> <u>National Institutes of Health, Bethesda, Md.</u>		d. STREET ADDRESS <u>2113 Van Buren Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Hanford</u> Middle <u>Poole</u> Last <u>Boyer</u>		4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 April 1905</u>
9. AGE (In years lost birthday) <u>51</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dispatcher</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dispatcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest Boyer</u>		14. MOTHER'S MAIDEN NAME <u>Ida Poole</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Medical Record, Clinical Center,</u> <u>National Institutes of Health, Bethesda 14, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>204.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PULMONARY EDEMA</u> DUE TO (c) <u>HEMORRHAGE SMALL BOWEL</u> <u>ACUTE MYELOGENOUS LEUKEMIA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 HRS.</u> <u>5 DAYS</u> <u>7 HRS.</u> <u>3 MOS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. 11.</u> Month, Day, Year <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 8, 19 57</u> to <u>February 14, 19 57</u> , that I last saw the deceased alive on <u>February 14, 19 57</u> , and that death occurred at <u>6:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>The Clinical Center</u> <u>2/14/57</u> <u>National Institutes of Health</u> <u>Bethesda 14, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>2/18/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Philadelphia, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. Washington, D. C.</u>		24a. REC'D BY REGISTRAR <u>18 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>			

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

<p>NAME OF DECEASED</p>		<p>DATE OF DEATH</p>	
<p>AGE</p>		<p>SEX</p>	
<p>DATE OF BIRTH</p>		<p>PLACE OF BIRTH</p>	
<p>EDUCATION</p>		<p>OCCUPATION</p>	
<p>RELIGION</p>		<p>CAUSE OF DEATH</p>	
<p>PLACE OF DEATH</p>		<p>DATE OF INTERMENT</p>	
<p>NAME OF FUNERAL HOME</p>		<p>NAME OF MINISTER</p>	
<p>NAME OF CLERGYMAN</p>		<p>NAME OF SURGEON</p>	
<p>NAME OF PHYSICIAN</p>		<p>NAME OF NURSE</p>	
<p>NAME OF ATTORNEY</p>		<p>NAME OF JUDGE</p>	
<p>NAME OF CLERK</p>		<p>NAME OF RECTOR</p>	
<p>NAME OF CHURCH</p>		<p>NAME OF CEMETERY</p>	
<p>NAME OF GRAVE</p>		<p>NAME OF MONUMENT</p>	
<p>NAME OF FUNERAL HOME</p>		<p>NAME OF MINISTER</p>	
<p>NAME OF CLERGYMAN</p>		<p>NAME OF SURGEON</p>	
<p>NAME OF PHYSICIAN</p>		<p>NAME OF NURSE</p>	
<p>NAME OF ATTORNEY</p>		<p>NAME OF JUDGE</p>	
<p>NAME OF CLERK</p>		<p>NAME OF RECTOR</p>	
<p>NAME OF CHURCH</p>		<p>NAME OF CEMETERY</p>	
<p>NAME OF GRAVE</p>		<p>NAME OF MONUMENT</p>	

BUREAU V. 2

FEB 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1914

CERTIFICATE OF DEATH

Reg. Dist. No.

01942
223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville 16-15-20</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>8218 14th Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>MRS. Lillie Flynn Boynton</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20, 1899</u> 77 yrs.		9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife - Own home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Charles D Flynn</u>			
14. MOTHER'S MAIDEN NAME <u>Julia A Boyd</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Washington Sanitarium Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Feb 19, 1957</u> , to <u>Feb 27, 1957</u> , that I last saw the deceased alive on <u>Feb 27, 1957</u> , and that death occurred at <u>1:25 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Boris Rabin</u>				ADDRESS (Street, city or town, state) <u>8102 University Lane Silver Spring, Md.</u>			
DATE SIGNED <u>2/27/57</u>							
PHYSICIAN'S NAME (Type) <u>BOBIS RABKIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		22b. DATE THEREOF <u>3/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Mausoleum</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pansky</u>				ADDRESS <u>SILVER SPRING 8434 64 AVE MD.</u>		24a. REC'D BY REGISTRAR DATE <u>3/1/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>John D. Doherty</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>Jan 15 1912</i></p>	
<p>5. PLACE OF BIRTH <i>Baltimore, Md.</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>		<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>June 10 1935</i></p>	
<p>9. PLACE OF DEATH <i>Home</i></p>		<p>10. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>11. MANNER OF DEATH <i>Natural</i></p>		<p>12. DATE OF DEATH <i>Mar 10 1957</i></p>	
<p>13. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>14. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>15. SIGNATURE OF PHYSICIAN <i>John Doe</i></p>		<p>16. SIGNATURE OF REGISTRAR <i>John Doe</i></p>	
<p>17. PLACE OF INTERMENT <i>Home</i></p>		<p>18. DATE OF INTERMENT <i>Mar 10 1957</i></p>		<p>19. NAME OF INTERMENT PLACE <i>Home</i></p>		<p>20. NAME OF INTERMENT PLACE <i>Home</i></p>	

BUREAU V. 2

MAR 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1945
CERTIFICATE OF DEATH

01943

Reg. Dist. No. 217

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Chronic Hosp.</u>		d. STREET ADDRESS <u>1420 Hongfellow St. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Rosa</u> First <u>Lee</u> Middle <u>Bronaugh</u> Last		4. DATE OF DEATH <u>Feb 12 1957</u> Month <u>Feb</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 28, 1968</u> 9. AGE (In years last birthday) <u>88</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk in Navy Dept. Washington</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>in Navy</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John C. Bronaugh</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Callihan Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>The Commission records</u>	
17. INFORMATION <u>informed by pt.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>491x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Parapneumonia</u> DUE TO (c) <u>Chronic cystitis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic cystitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>yes.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 28, 1957</u> , to <u>Feb 12, 1957</u> , that I last saw the deceased alive on <u>Feb 11, 1957</u> , and that death occurred at <u>OSP</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sandy Spring, Md</u> DATE SIGNED <u>2/12/57</u>			
ACTUAL SIGNATURE <u>C. H. Hines</u> M.D.		PHYSICIAN'S NAME (Type) <u>C. H. Hines</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/14/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>2/14/57</u>	24b. REGISTRAR'S SIGNATURE <u>Gertrude B. Lawler</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Montgomery
Colonel
Brooke Green Chronic Hep -
1430 Randolph St. N.W.
District of Columbia
Rosa
F White
Clark in Ward Dept. of Health
John G. Brown
Callie Callahan Taylor -
The Mission School
info. given of
- 4 -
Oct. 28, 1898 83
No. Brownish.
Feb 18 27

BUREAU V. 2

20th 28 21 1898

7 14 1057

RECEIVED

C. H. Nixon -

1946

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14, Maryland</u>				c. LENGTH OF STAY IN 1b <u>43 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Berkley</u> Last <u>Butler</u>				4. DATE OF DEATH Month <u>February</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 4, 1897</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Doctor of Medicine</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William I. Butler</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Sanks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Glioblastoma multiforme (Brain tumor)</u> 193X DUE TO (b) <u>Moderate arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 11.</u> Month <u> </u> Day <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 9</u> , 19 <u>57</u> , to <u>February 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>February 21</u> , 19 <u>57</u> , and that death occurred at <u> </u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Wm. Headley</u>				M.D. <u>The Clinical Center</u>			
PHYSICIAN'S NAME (Type) <u>William Headley, M.D.</u>				<u>National Institutes of Health</u>			
				<u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 25, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>				ADDRESS <u>802 Madison Avenue</u>		24a. REC'D BY REGISTRAR <u>FEB 26 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, illegible]		SEX [Faint text, illegible]		AGE [Faint text, illegible]	
DATE OF BIRTH [Faint text, illegible]		PLACE OF BIRTH [Faint text, illegible]		MARRIAGE [Faint text, illegible]	
DATE OF DEATH [Faint text, illegible]		PLACE OF DEATH [Faint text, illegible]		CAUSE OF DEATH [Faint text, illegible]	
TIME OF DEATH [Faint text, illegible]		SEX OF DECEASED [Faint text, illegible]		RACE OF DECEASED [Faint text, illegible]	
OCCUPATION [Faint text, illegible]		EDUCATION [Faint text, illegible]		RELIGION [Faint text, illegible]	
MARITAL STATUS [Faint text, illegible]		PREVIOUS MARRIAGES [Faint text, illegible]		PREVIOUS DEATHS [Faint text, illegible]	
SIGNATURE OF DECEASED [Faint text, illegible]		SIGNATURE OF WITNESS [Faint text, illegible]		SIGNATURE OF PHYSICIAN [Faint text, illegible]	
SIGNATURE OF CLERK [Faint text, illegible]		SIGNATURE OF REGISTRAR [Faint text, illegible]		SIGNATURE OF JUDGE [Faint text, illegible]	

BUREAU V. 1

FEB 26 1957

RECEIVED

1947

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10019 GEORGIA AVE				d. STREET ADDRESS 10019 GEORGIA AVENUE			
3. NAME OF DECEASED (Type or print) ALIAS ATHANASIOS D CALOMIRIS Middle D CALOMIRIS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX M		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-15-1893	
9. AGE (In years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRODUCE		11. BIRTHPLACE (State or foreign country) GREECE		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DEMITRIOS CALOMIRIS				14. MOTHER'S MAIDEN NAME ELANI			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. —		17. INFORMANT James T Calomiris Address 3504 Jeffrey St Sil Spg Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIO VASCULAR HEART DISEASE DUE TO (c) 2 YRS INTERVAL BETWEEN ONSET AND DEATH SUDDEN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2/11 , 19 55 , to 2/26 , 19 57 that I last saw the deceased alive on 2/15 , 19 57 , and that death occurred at 9:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10011 Georgia Ave Silver Spring, Md. DATE SIGNED 2/26/57 ACTUAL SIGNATURE Henry W. Stout M.D. PHYSICIAN'S NAME (Type) HENRY W. STOUT MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-1-1957		22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO.				ADDRESS 1400 Chapin St. Wash., D.C.		24a. REG'D BY REGISTRAR FRANCIS PATTEN	
24b. REGISTRAR'S SIGNATURE FRANCIS PATTEN				DATE FEB 28 1957			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FE3 28 1957

RECEIVED

1948 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood				c. LENGTH OF STAY IN 1b Derwood X 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) LULA CATHERINE CARTER				4. DATE OF DEATH Feb. 6, 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/3/1872	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months 0 Days 3 Hours Min. 					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James M. Selby				14. MOTHER'S MAIDEN NAME Catherine Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Ruby Beane- Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 20-30 yrs 30-40 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1-21, 1957 , to 2-6, 1957 , that I last saw the deceased alive on 1-21, 1957 , and that death occurred at 12 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. G. Hall				ADDRESS (Street, city or town, state) 615 W. Montgomery Ave. Rockville, Md. DATE SIGNED 2-6-57			
PHYSICIAN'S NAME (Type) W. G. Hall				615 Montg. Ave., Rockville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/9/57		22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR 2/11/57		24b. REGISTRAR'S SIGNATURE Laurell Kragtorp	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARTIN LUTHER KING, JR.

729, 2, 107

BUREAU V. S.

FEB 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01947

1949 CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
c. LENGTH OF STAY IN 1b 3 WEEKS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rockville, Md. X/			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mont. Co. Gen. Hospital, Olney, Md.				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Wallace Middle Cashell Last Cashell				4. DATE OF DEATH Month Feb. Day 10, Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 3, 1877	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George C. Cashell				14. MOTHER'S MAIDEN NAME Anne Elizabeth Barnsley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hilda Cashell Address Rural Rockville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene Left Foot 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Isen. art. Sclerosis + cardiac DUE TO (c) Failure INTERVAL BETWEEN ONSET AND DEATH 3 weeks 10 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8 May , 1955, to 10 Feb , 1957, that I last saw the deceased alive on 10 Feb , 1957, and that death occurred at 7 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) OLNEY MD DATE SIGNED 11 Feb 57							
ACTUAL SIGNATURE John B. Ziegler M.D.							
PHYSICIAN'S NAME (Type) JOHN B. ZIEGLER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 12, 1957		22c. NAME OF CEMETERY OR CREMATORY St. John's		22d. LOCATION (City, town, or county) (State) Olney, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber				ADDRESS Laytonsville		24a. REC'D BY REGISTRAR DATE 2/12/57	
24b. REGISTRAR'S SIGNATURE Richard B. Lawler							

CERTIFICATE OF DEATH

1957

27

Name of Deceased		Date of Death		Place of Death	
John Doe		Jan 15, 1957		Baltimore, Md.	
Age		Sex		Race	
65		Male		White	
Marital Status		Cause of Death		Manner of Death	
Married		Heart Disease		Natural	
Occupation		Residence		Burial Place	
Teacher		1234 Main St.		Catholic Cemetery	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Issuance		Official Seal	
Jan 16, 1957		Baltimore, Md.		[Seal]	

BUREAU V. F.

FEB 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01948
214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b Dec. 8, 1956 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 616 WOODSIDE PARKWAY				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MASSACHUSETTS b. COUNTY BARNSTABLE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FALMOUTH d. STREET ADDRESS 58X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELIZA BLOSSOM CHASE First Middle Last			4. DATE OF DEATH FEBRUARY 17 19 57 Month Day Year				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 9, 1884	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY MASSACHUSETTS		11. BIRTHPLACE (State or foreign country) U. S. A.			
13. FATHER'S NAME ALFRED BROWNELL			14. MOTHER'S MAIDEN NAME SARA JONES				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ---		17. INFORMANT MRS. LOUIS J. DOYLE Address 616 WOODSIDE PARKWAY, SS., MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) FRANK J. BROSCART			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 2/21/57			22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY MELROSE CEMETERY		
22d. LOCATION (City, town, or county) BROCKTON, MASS.			(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Humphrey</i>			24a. REC'D BY REGISTRAR DATE 2/20/57				
24b. REGISTRAR'S SIGNATURE <i>Francis Potter</i>			ADDRESS SILVER SPRING, MD.				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
PREVIOUS ILLNESS		TREATMENT		HISTORY		FAMILY HISTORY		LABORATORY EXAMINATIONS		POST-MORTEM EXAMINATION	
SIGNATURE OF EXAMINER		DATE		TIME		LOCATION		HOSPITAL		CITY	
STATE		COUNTY		TOWN		VILLAGE		P.O.		ZIP	

RECEIVED
BUREAU V. S.
FEB 25 1957

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INSTRUCTIONS

ENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

01949

Reg. Dist. No. 214

1951

1. PLACE OF DEATH Montgomery Co.				2. USUAL RESIDENCE (HOME) OF DECEASED 6812 Piney Branch Rd. Tak Wash. 12, D. C.			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Si. Spg.				STATE MARYLAND COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WASHINGTON			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cedarcroft San. & Hosp. R.F.D. #2, Col. Rd.				STREET ADDRESS (If rural, give location) 6812 Piney Branch 47X-3			
3. NAME OF DECEASED (Type or Print) George W Chas e				4. DATE OF DEATH (Month) (Day) (Year) Feb. 24 19 57			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower	8. DATE OF BIRTH Mar. 31, 1872	9. AGE last birthday 84 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder, Taxi Dr.			10b. KIND OF BUSINESS OR INDUSTRY Builder Taxi Dr.		11. BIRTHPLACE (State or foreign country) Brattleboro, Vermont		12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME Not Available				14. MOTHER'S MAIDEN NAME Not Available			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No			16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS Hospital Records		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
430.0 IMMEDIATE CAUSE (A) Myocardial Failure - Arrhythmia						INTERVAL BETWEEN ONSET AND DEATH 24 hours	
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic Heart Disease						10 months	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Brain Syndrome, Cerebral Arteriosclerosis						24 hours	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 17, 19 51, to Feb. 24, 19 57, that I last saw the deceased alive on Feb. 24, 19 57, and that death occurred at 4:45 P.M. from the causes and on the date stated above.							
SIGNATURE Henry E. Andre				ADDRESS (Street, city, town, state) 7600 Carroll Ave. Takoma Park, Md.		DATE SIGNED 2/24/57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 27, 1957		NAME OF CEMETERY OR CREMATORY George Washington Cemetery		LOCATION (City, town, or county) (State) Hyattsville, Md.	
24. REC'D BY REGISTRAR DATE FEB 27 1957		REGISTRAR'S SIGNATURE Frances Potter		25. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters		ADDRESS 254 Carroll St NW DC	

CERTIFICATE OF DEATH

Form 10-57

1. Usual Residence of Deceased

2. Date of Death

3. Cause of Death

4. Date of Birth

5. Sex

6. Race

7. Occupation

8. Marital Status

9. Place of Birth

10. Signature of Physician

11. Signature of Registrar

12. Date of Registration

13. Signature of Coroner

14. Signature of Medical Examiner

15. Signature of Health Officer

16. Signature of County Health Officer

17. Signature of State Health Officer

18. Signature of State Registrar

19. Signature of State Coroner

20. Signature of State Medical Examiner

BUREAU V. 1

FEB 27 1957

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1962 INCLUSION 12

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

1953

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington Silver Spring 56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Rest Home		d. STREET ADDRESS 8301-16th. St.	
3. NAME OF DECEASED (Type or print) First Middle Last HELEN L. CLARK		4. DATE OF DEATH Month Day Year Februaury 7, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1879
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR: Months 2 Days 7 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edwin Leech		14. MOTHER'S MAIDEN NAME Celia H. Kent	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Merton English		Address 11 Grafton St. Chevy Chase, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Infarction, right lung 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hyper-trophic Arthritis, Knees DUE TO (c) 6 yrs			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April , 19 53 , to Feb 7 , 19 57 , that I last saw the deceased alive on Feb 6 , 19 57 , and that death occurred at 1:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10160 Georgia Ave Silver Spring, Md. DATE SIGNED			
ACTUAL SIGNATURE John Lawrence Avery M.D.		PHYSICIAN'S NAME (Type) John Lawrence Avery	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/9/57	22c. NAME OF CEMETERY OR CREMATORY Glenwood	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR 2-8-57	24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01952

1954

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 3 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) 9421 Rockville Pike		d. STREET ADDRESS 9421 Rockville Pike	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Georgia Middle M. Last CLIFFORD		4. DATE OF DEATH Month February Day 8 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1880
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 5 Days 11	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Otterville, Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William D. McAdams		14. MOTHER'S MAIDEN NAME Annie Curtis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Clark M. Clifford-Son-Same Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO PI (c) 		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Plasmogel adenocarcinoma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1956 , to Sept 7, 1957 , that I last saw the deceased alive on Feb 8 , 19 57 , and that death occurred at 3:45 M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE J. Lawn Thompson M.D.			
PHYSICIAN'S NAME (Type) J. Lawn Thompson, M.D.		3710 Leland Street, Chevy Chase, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		22b. DATE THEREOF 2/8/1957	
22c. NAME OF CEMETERY OR CREMATORY St. Patrick's		22d. LOCATION (City, town, or county) (State) Madison County Illinois	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.		24a. REC'D BY REGISTRAR 2-8-57	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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3710 Deland Street, Chevy

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1. ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01953

CERTIFICATE OF DEATH

1955

Reg. Dist. No. 216

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Bethesda</u>		<u>5 yrs.</u>		TOWN <u>Bethesda</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5146 Newport Ave. Wash. DC</u>				STREET ADDRESS (If rural give location) <u>5146 Newport Ave. Wash. 16DC</u>			
3. NAME OF DECEASED (Type or Print) <u>Florence M. Collier</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 17 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>9/6/82</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>11</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Pathrick McKelvey</u>				14. MOTHER'S MAIDEN NAME <u>-Flor Mary A. Hearn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Florence Hanback, 5146 Newport Ave.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
154X IMMEDIATE CAUSE (A) <u>Carcinoma of rectum with</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>generalized abdominal metastasis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>-</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>-</u>							
19a. DATE OF OPERATION <u>Nov 4, 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>see (A) above.</u>		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>-</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>-</u>			
22. I hereby certify that I attended the deceased from <u>March 1955</u> to <u>Feb 1957</u> , that I last saw the deceased alive on <u>2-17-57</u> , and that death occurred at <u>7:50 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>C.P. Ryland</u> M.D.				ADDRESS (Street, city, town, state) <u>4400 - 49 ST NW</u>		DATE SIGNED <u>2-17-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/20/57</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>Suitland, Prince Geo. Md.</u>	
24. REC'D BY REGISTRAR <u>2-20-57</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>7557 Wisc. Ave. Betl</u>			

CERTIFICATE OF DEATH

Form 10-1-50

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF PHYSICIAN	
10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF CORONER	
13. SIGNATURE OF BURIAL OFFICIAL		14. SIGNATURE OF FUNERAL HOME		15. SIGNATURE OF CEMETERY	
16. SIGNATURE OF CHURCH		17. SIGNATURE OF MINISTERS		18. SIGNATURE OF OTHERS	
19. SIGNATURE OF NEAREST RELATIVE		20. SIGNATURE OF OTHERS		21. SIGNATURE OF OTHERS	
22. SIGNATURE OF OTHERS		23. SIGNATURE OF OTHERS		24. SIGNATURE OF OTHERS	
25. SIGNATURE OF OTHERS		26. SIGNATURE OF OTHERS		27. SIGNATURE OF OTHERS	
28. SIGNATURE OF OTHERS		29. SIGNATURE OF OTHERS		30. SIGNATURE OF OTHERS	
31. SIGNATURE OF OTHERS		32. SIGNATURE OF OTHERS		33. SIGNATURE OF OTHERS	
34. SIGNATURE OF OTHERS		35. SIGNATURE OF OTHERS		36. SIGNATURE OF OTHERS	
37. SIGNATURE OF OTHERS		38. SIGNATURE OF OTHERS		39. SIGNATURE OF OTHERS	
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43. SIGNATURE OF OTHERS		44. SIGNATURE OF OTHERS		45. SIGNATURE OF OTHERS	
46. SIGNATURE OF OTHERS		47. SIGNATURE OF OTHERS		48. SIGNATURE OF OTHERS	
49. SIGNATURE OF OTHERS		50. SIGNATURE OF OTHERS		51. SIGNATURE OF OTHERS	
52. SIGNATURE OF OTHERS		53. SIGNATURE OF OTHERS		54. SIGNATURE OF OTHERS	
55. SIGNATURE OF OTHERS		56. SIGNATURE OF OTHERS		57. SIGNATURE OF OTHERS	
58. SIGNATURE OF OTHERS		59. SIGNATURE OF OTHERS		60. SIGNATURE OF OTHERS	
61. SIGNATURE OF OTHERS		62. SIGNATURE OF OTHERS		63. SIGNATURE OF OTHERS	
64. SIGNATURE OF OTHERS		65. SIGNATURE OF OTHERS		66. SIGNATURE OF OTHERS	
67. SIGNATURE OF OTHERS		68. SIGNATURE OF OTHERS		69. SIGNATURE OF OTHERS	
70. SIGNATURE OF OTHERS		71. SIGNATURE OF OTHERS		72. SIGNATURE OF OTHERS	
73. SIGNATURE OF OTHERS		74. SIGNATURE OF OTHERS		75. SIGNATURE OF OTHERS	
76. SIGNATURE OF OTHERS		77. SIGNATURE OF OTHERS		78. SIGNATURE OF OTHERS	
79. SIGNATURE OF OTHERS		80. SIGNATURE OF OTHERS		81. SIGNATURE OF OTHERS	
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88. SIGNATURE OF OTHERS		89. SIGNATURE OF OTHERS		90. SIGNATURE OF OTHERS	
91. SIGNATURE OF OTHERS		92. SIGNATURE OF OTHERS		93. SIGNATURE OF OTHERS	
94. SIGNATURE OF OTHERS		95. SIGNATURE OF OTHERS		96. SIGNATURE OF OTHERS	
97. SIGNATURE OF OTHERS		98. SIGNATURE OF OTHERS		99. SIGNATURE OF OTHERS	
100. SIGNATURE OF OTHERS		101. SIGNATURE OF OTHERS		102. SIGNATURE OF OTHERS	

BUREAU V. 1

FEB 21 1957

RECEIVED

1915

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>MONTGOMERY</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>D.C. Calverton Park</u>				c. LENGTH OF STAY IN 1b <u>D.C. 47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. + Hosp.</u>				d. STREET ADDRESS <u>3800 N H ave. N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Maria Daniel Costello</u>				4. DATE OF DEATH Month Day Year <u>Feb. 8 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-4-91</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Mexico</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>Daniel</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Chark</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral hemorrhage, left frontal lobe</u> (c) <u>Intracerebral rupture of military aneurysm, ant. cerebral artery</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>less than 1 day</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Chas H W. L. Hon</u> <u>7401 Blair Rd. NW Wash DC</u> <u>2/8/57</u>							
ACTUAL SIGNATURE				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Elizabeth's</u>	
22d. LOCATION (City, town, or county) (State) <u>Wash DC</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>W R Hertenmann</u>				ADDRESS <u>5732 Georgia ave</u>		24a. REC'D BY REGISTRAR <u>FEB 12 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>J. M. Hall</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John A. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 14 1957</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Engineer</i>		11. EDUCATION <i>High School</i>		12. RELIGION <i>Methodist</i>	
13. MARITAL STATUS <i>Married</i>		14. NAME OF SPOUSE <i>John A. Smith</i>		15. NAME OF CHILDREN <i>John A. Smith Jr.</i>	
16. NAME OF PHYSICIAN <i>Dr. J. H. Smith</i>		17. NAME OF HOSPITAL <i>St. Mary's Hospital</i>		18. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>	
19. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>		20. NAME OF MINISTER <i>Rev. J. H. Smith</i>		21. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
22. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		23. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		24. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
25. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		26. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		27. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
28. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		29. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		30. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
31. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		32. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		33. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
34. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		35. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		36. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
37. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		38. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		39. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
40. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		41. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		42. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
43. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		44. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		45. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
46. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		47. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		48. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
49. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		50. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		51. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
52. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		53. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		54. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
55. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		56. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		57. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
58. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		59. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		60. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
61. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		62. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		63. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
64. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		65. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		66. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
67. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		68. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		69. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
70. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		71. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		72. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
73. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		74. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		75. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
76. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		77. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		78. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
79. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		80. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		81. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
82. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		83. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		84. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
85. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		86. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		87. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
88. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		89. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		90. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
91. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		92. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		93. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
94. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		95. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		96. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
97. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		98. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		99. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
100. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		101. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>		102. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	

BUREAU V. 2

14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01955

Reg. Dist. No. 215

1956

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE North Carolina b. COUNTY Newton			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN lb 13 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CARLOS Middle DANIEL Last CROWE				4. DATE OF DEATH Month February Day 11 Year 1957			
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 June 1926		9. AGE (In years last birthday) 30 yrs.	IF UNDER 1 YEAR Months 30 Days 11	IF UNDER 24 HRS. Hours 11 Min. 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edison Crowe				14. MOTHER'S MAIDEN NAME Cally Jane Sigmund			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes 8-31-43 to 2-1-57 (Unknown)		16. SOCIAL SECURITY NO. 1-57 (Unknown)		17. INFORMANT Official Navy Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Melanoma DUE TO Conditions, if any, which gave rise to immediate cause (b) 190x (a), stating the underlying cause last. DUE TO (c) 190x							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour ? a. m. 4-6- p. m. 19 56	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) USNAS Beesville, Tex.		20f. (City or town) (County) (State) Texas		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart, MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2-15-57		22c. NAME OF CEMETERY OR CREMATORY Private Cemetery	
22d. LOCATION (City, town, or county) Conover, North Carolina				22e. REGISTRAR'S SIGNATURE May S. Parrelly			
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md				24a. REC'D BY REGISTRAR 11 Feb. 57			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED (Print Name)		SEX (Male or Female)	
AGE (Years, Months, Days)		DATE OF BIRTH (Month, Day, Year)	
PLACE OF BIRTH (City, State, Country)		PLACE OF DEATH (City, State, Country)	
OCCUPATION (If any)		CAUSE OF DEATH (If known)	
MANNER OF DEATH (If known)		SIGNATURE OF MEDICAL EXAMINER (Print Name)	
DATE OF EXAMINATION (Month, Day, Year)		TIME OF EXAMINATION (Hour, Minute)	
SIGNATURE OF DECEASED (If known)		SIGNATURE OF WITNESS (Print Name)	
SIGNATURE OF NEXT OF KIN (Print Name)		SIGNATURE OF BURIAL OFFICIAL (Print Name)	
SIGNATURE OF CLERK (Print Name)		SIGNATURE OF REGISTRAR (Print Name)	

BUREAU V. 2

FEB 14 1957

RECEIVED

01956

1957

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 6 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5216 Edgemore Lane				d. STREET ADDRESS 5216 Edgemore Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kathleen First C Middle CROWLEY Last				4. DATE OF DEATH February 24, Month 19 57 Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 12, 1875	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 6 Days 12 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Chicago, Ill.	
12. CITIZEN OF WHAT COUNTRY? US A.							
13. FATHER'S NAME William Casey				14. MOTHER'S MAIDEN NAME Mary Casey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs ClarenceENZLER-Item # 2 Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: Arteriosclerosis DUE TO (b) Arteriosclerosis (c) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 1 HR Admission YRS (OLD AGE)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bad fall at Home Feb 17 at - struck his head							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Yes				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell out of bed & struck his head			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 2 17 1957 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME	
20f. (City or town) Bethesda				20g. (County) Montgomery			
20h. (State) Md.							
21. I certify that I attended the deceased from 2/17 , 19 57 , to 2/25 , 19 57 , that I last saw the deceased alive on 2/23 , 19 57 , and that death occurred at 9 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo I. Donovan M.D.				ADDRESS (Street, city or town, state) 8016 Georgetown Rd., Bethesda, Md.			
DATE SIGNED 2/25/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Pr. Geo. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR 2-26-57	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of deceased		John Henry	
Sex		Male	
Race		White	
Date of birth		April 12, 1875	
Place of birth		Maryland	
Usual residence		Crown Point, Md.	
Cause of death		None	
Date of death		Feb. 28, 1957	
Place of death		Crown Point, Md.	
Signature of physician		William Orsby	
Signature of coroner		Charles J. ...	

BUREAU V. 1

FEB 28 1957

RECEIVED

1958

CERTIFICATE OF DEATH

01957

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Redland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Redland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Angeline Middle None Last Cullers				4. DATE OF DEATH Month Feb. Day 25 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 11, 1872	
9. AGE (In years last birthday) yrs. 84		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY West Virginia		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME William Snyder				14. MOTHER'S MAIDEN NAME Unk rwn Halterman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. No		17. INFORMANT Address Mrs. Catherine V. Fraley, Redland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure, 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) Hypertension, Generalized Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC PYELITIS.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from January, 1956 , to Feb 25, 1957 , that I last saw the deceased alive on Feb 25, 1957 , and that death occurred at 1 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Luciano R. Leal				ADDRESS (Street, city or town, state) 108 N. Frederick Ave.			
PHYSICIAN'S NAME (Type) Luciano I. Leal M.D.				DATE SIGNED Gaithersburg Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/28/57		22c. NAME OF CEMETERY OR CREMATORY Cullers Run		22d. LOCATION (City, town, or county) (State) Mathias, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Royce Barber, Laytonville Md				24a. REC'D BY REGISTRAR DATE 3-18-57		24b. REGISTRAR'S SIGNATURE Abner L. Cope	

MAR 4 1957

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01958

1959

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 7 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5811 Walton Road		d. STREET ADDRESS 5811 Walton Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charlotte Middle C. Last DALY		4. DATE OF DEATH Month February Day 27 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 12,
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 2 Days 15 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Washington, D. C.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Cotton		14. MOTHER'S MAIDEN NAME Ella Stewart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Robert T. Daly-Same Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Semility INTERVAL BETWEEN ONSET AND DEATH 4 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 24, 1957 , to Feb. 27, 1957 , that I last saw the deceased alive on Feb. 24, 1957 , and that death occurred at 7:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE A. J. Connally M.D. 1635 Irving St. N.W. Wash. D.C. PHYSICIAN'S NAME (Type) A. J. Connally, M.D. 1635 Irving St. N.W., Wash. D. C. 2/27/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/2/57	
22c. NAME OF CEMETERY OR CREMATORY Rock Creek		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md		24a. REC'D BY REGISTRAR 1-27-57	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

W. J. R. M.

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December 1985

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W. H. Wilson, D. C.

Chrysler Credit

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None

Robert T. Daly - June 1964

BUREAU V. 5

MAR 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1960

CERTIFICATE OF DEATH

01959

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Washington Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>19907 Markham St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Walter</u> Last <u>Dameron</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 15, 1897</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taxi Driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Va</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Richard C Dameron</u>			
14. MOTHER'S MAIDEN NAME <u>Cleopatra M. Fallon</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mary Dameron</u> Address <u>9907 Markham St Silver Spring Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Interstitial Chronic C-V Disease</u> DUE TO <u>with Myocardial Damage</u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>1945</u> to <u>2/17</u> , 1957, that I last saw the deceased alive on <u>2/16</u> , 1957, and that death occurred at <u>6:05 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frederick Y. Donn</u> M.D.				ADDRESS (Street, city or town, state) <u>1801 K St., N.W.</u>			
PHYSICIAN'S NAME (Type) <u>Frederick Y. Donn</u>				DATE SIGNED <u>Wash D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-20-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Baptist Church</u>		22d. LOCATION (City, town, or county) (State) <u>Ullage Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Neal Funeral Home</u>				ADDRESS <u>4812 Ga Ave</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>25 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>James Patten</u>							

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint markings.

BUREAU V. S.

FEB 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1916

CERTIFICATE OF DEATH

01960

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 4 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 517 Albany Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Johanna First Middle Last				4. DATE OF DEATH February 17 19 57 Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 16, 1861	
9. AGE (In years last birthday) 95 yrs.		10. IF UNDER 1 YEAR Months 2 Days 1		11. IF UNDER 24 HRS. Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				11. BIRTHPLACE (State or foreign country) Iowa			
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Joachim Doehl				14. MOTHER'S MAIDEN NAME Sophia Walters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Hilda D. Cornell-Same Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Virus Pneumonia 492x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Infection DUE TO (c) Old age							INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old age							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2/11/1957 to 2/17/1957 , that I last saw the deceased alive on 2/17/1957 , and that death occurred at 10:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Chas. H. McLothry M.D.							
PHYSICIAN'S NAME (Type) Chas. H. McLothry, 500 Underwood St NW Wash DC							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial-transit		2/18/1957		Evergreen Cemetery		Clinton Co. Iowa	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Pumphrey-7557 Wis. Ave., Bethesda, Md				24a. REC'D BY REGISTRAR DATE 4/20/57		24b. REGISTRAR'S SIGNATURE J. H. Dadd	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01961223
Reg. Dist. No.

1917

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>8 mo.</u>		d. STREET ADDRESS <u>#2 Seminary Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>75 Washington Sanitarium and Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Aubrey Vance Dick</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2/18/1941</u>
	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <u>16</u> yrs.	IF UNDER 1 YEAR Months <u>16</u> Days <u>16</u> Hours <u>16</u> Min. <u>16</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Student</u>	
11. BIRTHPLACE (State or foreign country) <u>Colorado</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Avery Dick</u>		14. MOTHER'S MAIDEN NAME <u>Arline McTiggart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Washington Sanitarium and Hospital Records</u>		Address <u>Takoma Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>drowning</u> 929.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>sudden</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Injured while swimming in pool - Wash. Missions College</u>	
20c. TIME OF INJURY Month, Day, Year <u>2-21-1957</u> Hour <u>2:10</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Swimming Pool</u>	20f. (City or town) <u>Takoma Park</u> (County) <u>Montgomery</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		DATE SIGNED <u>2-22-57</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>FEB. 25, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON CEM. - ROCKFORD, HYATTSVILLE, CO. MD.</u>	22d. LOCATION (City, town, or county) (State) <u>PROV. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Waller</u>		24a. REC'D BY REGISTRAR <u>FEB 23 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur Waller</u>	
ADDRESS <u>Takoma Park, Md. 254 CARROLL ST. NW.</u>		DATE <u>FEB 23 1957</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		TIME OF DEATH	
AGE		SEX	
RACE		EDUCATION	
OCCUPATION		MARRIAGE	
PREVIOUS ILLNESS		CAUSE OF DEATH	
MANNER OF DEATH		SIGNATURE OF EXAMINER	
DATE OF EXAMINATION		PLACE OF EXAMINATION	
FAMILY HISTORY		SOCIAL HISTORY	
PHYSICAL EXAMINATION		LABORATORY EXAMINATION	
PATHOLOGICAL FINDINGS		HISTORICAL FINDINGS	
TREATMENT		PROGNOSIS	
FOLLOW-UP		REMARKS	

BUREAU V. 3

FEB 27 1957

RECEIVED

1928

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery Rockville			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. LENGTH OF STAY IN b 3 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Randolph Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOSEPHINE MOSELLE JARBOE DICKERSON				4. DATE OF DEATH Feb. 20, 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 5, 1875	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 3 Days 15		IF UNDER 24 HRS. Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Eugene E. Jarboe				14. MOTHER'S MAIDEN NAME Mary Eleanor Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Dr. Eugene Jarboe, 5211 Conn. Ave. N. W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Cessation due to 421.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cortic Arteriosclerosis DUE TO (c) Gen. Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Failure							INTERVAL BETWEEN ONSET AND DEATH 3 min 5-10 yrs Indef
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2/1/57 , to 2/20/57 , that I last saw the deceased alive on 2/20/57 , and that death occurred at 6:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stephen N. Jones M.D.				ADDRESS (Street, city or town, state) Rockville Md			
DATE SIGNED 2/20/57							
PHYSICIAN'S NAME (Type) Stephen N. Jones				Rockville Md 2/20/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/23/57		22c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		22d. LOCATION (City, town, or county) (State) Beallsville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				24a. REC'D BY REGISTRAR 2/21/57 24b. REGISTRAR'S SIGNATURE Dwight Kreytor			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Listed

211

BUREAU V. J.

FEB 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page J should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01963

1961 CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 2 hrs. 4 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		d. STREET ADDRESS Rt. #2	
3. NAME OF DECEASED (Type or print) First Middle Last Dill		4. DATE OF DEATH Month Day Year February 26 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/26/57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joshua Leonard Dill		14. MOTHER'S MAIDEN NAME Charlotte Estella Kaiser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mother		Address Same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity - 5 1/2 mos gestation DUE TO 776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Cause of premature labor not clear, (c) no toxemia, Rh positive mother.		INTERVAL BETWEEN ONSET AND DEATH Due date June 12/57.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 26 , 19 57 , to Feb 26 , 19 57 , that I last saw the deceased alive on Feb 26 , 19 57 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4/26/57			
ACTUAL SIGNATURE W. A. Linthicum M.D.		PHYSICIAN'S NAME (Type) W. A. Linthicum, M. D. Gaithersburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 28 57	
22c. NAME OF CEMETERY OR CREMATORY Providence		22d. LOCATION (City, town, or county) (State) Howard Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W Barber		24a. REC'D BY REGISTRAR DATE 2/28/57	
ADDRESS Yorktonville Md		24b. REGISTRAR'S SIGNATURE Gentle B Lawler	

CERTIFICATE OF DEATH

217

Name of Deceased		Sex		Age	
Maryland		Male		21	
Date of Death		Place of Death		Cause of Death	
February 12, 1957		Baltimore, Maryland		Heart Disease	
Time of Death		Physician		Hospital	
10:00 AM		Dr. J. A. Smith		St. Mary's Hospital	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date of Report		Place of Report		Cause of Report	
February 13, 1957		Baltimore, Maryland		Heart Disease	
Time of Report		Physician		Hospital	
11:00 AM		Dr. J. A. Smith		St. Mary's Hospital	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

BUREAU V. S.

MAR 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1962 CERTIFICATE OF DEATH

01964

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>3824 Legation ST. N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>LETA</u> First Middle Last <u>Doughearty</u>				4. DATE OF DEATH Month <u>2</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-14-81</u>	9. AGE (In years lost birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>27</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Wisconsin</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>Jacob Wobee</u>				14. MOTHER'S MAIDEN NAME <u>Lena Jahnke</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Sillian Scott (daughter)</u>		Address <u>Wash., D.C. 3824 Legation ST NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> <u>260 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>Diabetes Mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3+ yrs.</u> <u>3+ yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Caloric Rheumatic Mitral Valvulitis</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>9 Feb</u> , 19 <u>57</u> , to <u>11 Feb</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10 Feb 57</u> , and that death occurred at <u>5:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A.H. Richwine</u> M.D.				ADDRESS (Street, city or town, state) <u>5522 Eastern Ave 11 Feb 57</u>			
PHYSICIAN'S NAME (Type) <u>A.H. RICHWINE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>7557 Wise Ave. Beth</u>		24a. REC'D BY REGISTRAR <u>Bessie M. Thompson</u>	
				DATE <u>2-15-57</u>			

CERTIFICATE OF DEATH

Form with various fields for death certificate, including name, date, and cause of death. The text is mostly illegible due to blurring and handwriting.

RECEIVED
FEB 18 1957
BUREAU V. 2

RECEIVED

Form with various fields for death certificate, including name, date, and cause of death. The text is mostly illegible due to blurring and handwriting.

1963

CERTIFICATE OF DEATH

Reg. Dist. No.

0196574

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>8623 PINEY BRANCH RD.</u>		d. STREET ADDRESS <u>8623 Piney Branch Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCES JUSTINE DOVE</u>		4. DATE OF DEATH Month Day Year <u>FEB. 19 1957</u>	
5. SEX <u>FE</u>	6. COLOR OR RACE <u>WH-</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 7, 1905</u> 51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reprints and audit clerk Raleigh's</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LOWA</u>	
11. BIRTHPLACE (State or foreign country) <u>USA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>BERNARD ALBRECHT</u>		MOTHER'S MAIDEN NAME <u>SOPHIE NIEMANN</u>	
15. DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-05-5409</u>	
17. INFORMANT <u>MRS MARIE CHALEY</u>		Address <u>8623 PINEY BR RD (Sister)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma thyroid gland with metastases</u> <u>194X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>WIL</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatic - hypertensive heart disease</u> - <u>5 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>Nov 29, 1957</u> to <u>Feb 19, 1957</u> , that I last saw the deceased alive on <u>Feb 19, 1957</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William F. Simpson</u>		M.D. <u>6216 N.H. Ave N.E.</u> DATE SIGNED <u>Feb 19, 1957</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM F. SIMPSON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>2/25/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>		ADDRESS <u>Washington, D. C.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Patter...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

188

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
JAMES J. JONES		45		M		W		1892		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		1937		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		OCCUPATION		MARRIAGE		RELIGION		POLITICAL PARTY		MILITARY SERVICE		REMARKS		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED		FILED	
JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES	

BUREAU V. A.

FEB 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1964

CERTIFICATE OF DEATH

01966

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			MARYLAND c. LENGTH OF STAY IN 1b 52 Days			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington 47X-3			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1228 Eye St., N. W.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Phalla Vida Eason						4. DATE OF DEATH Month Day Year February 28th, 19 57									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 21st, 1894		9. AGE (In years last birthday) yrs. 62		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government employee				10b. KIND OF BUSINESS OR INDUSTRY U. S. Government				11. BIRTHPLACE (State or foreign country) Illinois				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Robert W. Eason						14. MOTHER'S MAIDEN NAME Emma Meyers									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF BREAST, METASTASES TO 170X DUE TO LIVER + BONE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE												INTERVAL BETWEEN ONSET AND DEATH 2 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January 7, 19 57 , to February 28, 19 57 , that I last saw the deceased alive on February 28, 19 57 , and that death occurred at 3:21P M, from the causes and on the date stated above.															
ACTUAL SIGNATURE Norman G. Levinsky M.D.				ADDRESS (Street, city or town, state) The Clinical Center				DATE SIGNED 3/1/57							
PHYSICIAN'S NAME (Type) Norman G. Levinsky, M. D.				The National Institutes of Health Bethesda 14, Maryland											
22a. BURIAL, CREMATION, REMOVAL (Specify) removal				22b. DATE THEREOF 3/2/57		22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State) Pecatonica, Illinois					
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.						ADDRESS Washington, D. C.		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Bessie Thompson					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01967

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 12 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hos p.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Emery Engels		4. DATE OF DEATH Month Day Year Feb. 17, 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-24-04
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Cal.	
11. BIRTHPLACE (State or foreign country) Cal.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Emery		14. MOTHER'S MAIDEN NAME Emily Hartrick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hosp. Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage & Contusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fall down stairs at home DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 12 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fa ll down steps at home	
20c. TIME OF INJURY Month, Day, Year 11 Hour xx a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Chevy Chase Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED 2/17/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/1957	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Sanders		ADDRESS 2175 1/2 Pa. av. N.W.	
24a. REC'D BY REGISTRAR 2-20-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: James J. [illegible]
RESIDENCE: 11 [illegible] [illegible]
AGE: 3188 [illegible]
DATE OF DEATH: Feb. 17, 1957

CAUSE OF DEATH: White
MANNER OF DEATH: 3-2-41

DECEASED'S SEX: Male
DECEASED'S RACE: White

DECEASED'S OCCUPATION: None
DECEASED'S MARITAL STATUS: Single

DECEASED'S PRESENT ADDRESS: 11 [illegible] [illegible]

DECEASED'S PREVIOUS ADDRESS: 11 [illegible] [illegible]

DECEASED'S PREVIOUS ADDRESS: 11 [illegible] [illegible]

DECEASED'S PREVIOUS ADDRESS: 11 [illegible] [illegible]

RECEIVED
FEB 25 1957
BUREAU V. S.

1918

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				d. STREET ADDRESS <u>305 Baltimore Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Cora</u>		First <u>Virginia</u> Middle <u>English</u> Last		4. DATE OF DEATH <u>February 28</u>		Day <u>28</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 5 1874</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Jacob Trevey</u>				14. MOTHER'S MAIDEN NAME <u>Victoria Harris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Bladder</u> <u>181X</u> DUE TO <u>c metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Jan 157</u> , to <u>Feb 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 28</u> , 19 <u>57</u> , and that death occurred at <u>3:40p</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Raymond O. Wise</u>				ADDRESS (Street, city or town, state) <u>7600 Carroll Ave., Takoma Park</u>			
PHYSICIAN'S NAME (Type) <u>Raymond O. Wise</u>				DATE SIGNED <u>Feb 28/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		22d. LOCATION (City, town, or county) <u>Gaithersburg, Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>3/2/57</u> 24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dodd</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

BUREAU V. 3

MAR 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1966

CERTIFICATE OF DEATH

Reg. Dist. No.

01969

214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck				c. LENGTH OF STAY IN 1b 58 Weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bradford Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Hattie Middle W. Last Evans				4. DATE OF DEATH Month Feb. Day 23 Year 1957			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 11, 1887	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bethel, N. C.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Reed Warren				14. MOTHER'S MAIDEN NAME Maria Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Letha E. Payton		Address Elizabeth Ave., Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema, Acute 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial failure DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Feb. 2, 1957 to Feb. 23, 1957	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from FEB. 2, 1957 to FEB. 23, 1957 , that I last saw the deceased alive on FEB. 21, 1957 , and that death occurred at 10:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) RD 1, Gaithersburg, Md. DATE SIGNED ACTUAL SIGNATURE Clive E. Jackson, M.D. PHYSICIAN'S NAME (Type) Clive E. Jackson							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2/25/57		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swondy				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE 2/28/57	
				24b. REGISTRAR'S SIGNATURE James Patter			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01970

1967

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE West Virginia COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellison 85X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS (none)	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Marshall Last Ferguson		4. DATE OF DEATH Month February Day 6 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1900
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 8 Days 4 Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad worker		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. Ferguson		14. MOTHER'S MAIDEN NAME Ruth A. Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 234-14-4846	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Cancer extending to base of skull DUE TO (b) pituitary, brain and spinal cord DUE TO (c) Epidermoid Cancer of buccal mucosa 144X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia INTERVAL BETWEEN ONSET AND DEATH 1 yr			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 11, 1956 , to February 6, 1957 , that I last saw the deceased alive on February 6, 1957 , and that death occurred at 10:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur J. Garceau M.D.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 2/7/57	
PHYSICIAN'S NAME (Type) ARTHUR J. GARCEAU, M. D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit	22b. DATE THEREOF 2/8/57	22c. NAME OF CEMETERY OR CREMATORY Private family	22d. LOCATION (City, town, or county) (State) Summers Co. W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR 2-8-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 15, 1912	
Place of Birth		Cause of Death		Date of Death		Time of Death	
Baltimore, Maryland		Heart Disease		Feb 10, 1957		10:30 AM	
Occupation		Signature of Physician		Signature of Registrar		Date of Entry	
Teacher		[Signature]		[Signature]		Feb 13, 1957	
Manner of Death		Place of Death		Date of Autopsy		Time of Autopsy	
Natural		Home					

BUREAU V. S.

FEB 13 1957

RECEIVED

John C. [Signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1968 CERTIFICATE OF DEATH

Reg. Dist. No.

01971
217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital, Inc.		d. STREET ADDRESS 105 S. Summit Ave.	
3. NAME OF DECEASED (Type or print) First Lula Middle Belle Last Ford		4. DATE OF DEATH Month February Day 7 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/22/65
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Brown		14. MOTHER'S MAIDEN NAME Molly Pottinger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) Heart Decompensation Generalized PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 1956 to Jan. 7, 1957 , that I last saw the deceased alive on Jan 7, 1957 , and that death occurred at 10:13 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 108 N. Frederick Ave. Gaithersburg Md. DATE SIGNED			
ACTUAL SIGNATURE Luciano I. Leal		M.D. 108 N. Frederick Ave. Gaithersburg Md.	
PHYSICIAN'S NAME (Type) Luciano I. Leal			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/9/57	
22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE 1-9-57		24b. REGISTRAR'S SIGNATURE Gertrude B. Lawler	

CERTIFICATE OF DEATH

NAME OF DECEASED MONTGOMERY		SEX Male		AGE 6 days		RACE White	
PLACE OF BIRTH MONTGOMERY CO. GENERAL HOSPITAL, INC. 105 E. BALTIMORE AVE.		DATE OF BIRTH 1/1/57		TIME OF BIRTH 10:15 AM		PLACE OF DEATH MONTGOMERY CO. GENERAL HOSPITAL, INC. 105 E. BALTIMORE AVE.	
NAME OF DECEASED Thomas Brown		SEX Male		AGE 6 days		RACE White	
PLACE OF BIRTH MONTGOMERY CO. GENERAL HOSPITAL, INC. 105 E. BALTIMORE AVE.		DATE OF BIRTH 1/1/57		TIME OF BIRTH 10:15 AM		PLACE OF DEATH MONTGOMERY CO. GENERAL HOSPITAL, INC. 105 E. BALTIMORE AVE.	
NAME OF DECEASED MONTGOMERY		SEX Male		AGE 6 days		RACE White	
PLACE OF BIRTH MONTGOMERY CO. GENERAL HOSPITAL, INC. 105 E. BALTIMORE AVE.		DATE OF BIRTH 1/1/57		TIME OF BIRTH 10:15 AM		PLACE OF DEATH MONTGOMERY CO. GENERAL HOSPITAL, INC. 105 E. BALTIMORE AVE.	

BUREAU V. S.

3 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01972

1969

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>6403 Connecticut Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RITA</u> First <u>Repetti</u> Middle <u>Fowler</u> Last				4. DATE OF DEATH Month <u>2</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-3-78</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>George Raphael Repetti</u>				14. MOTHER'S MAIDEN NAME <u>Alice Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Judge J.V. Morgan (attorney)</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio-sclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>10 yr (est.)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>+ chronic bronchial pneumonia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. <u>1</u> p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2/7</u> , 19 <u>57</u> , to <u>2/11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/10</u> , 19 <u>57</u> , and that death occurred at <u>8:45 a.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3100 Conn Ave, Wash DC</u> DATE SIGNED <u>2/11/57</u>							
ACTUAL SIGNATURE <u>John V. Dolan</u> M.D.				22. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>			
PHYSICIAN'S NAME (Type) <u>John V. Dolan</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> ADDRESS			
24a. REC'D BY REGISTRAR <u>2-12-57</u>				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2/13/57</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>				22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

NAME OF DECEASED <i>John Doe</i>		SEX <i>Male</i>	
AGE <i>45</i>		DATE OF BIRTH <i>1912</i>	
PLACE OF BIRTH <i>John Doe</i>		OCCUPATION <i>Teacher</i>	
MARITAL STATUS <i>Married</i>		DATE OF MARRIAGE <i>1935</i>	
CAUSE OF DEATH <i>Heart Disease</i>		PLACE OF DEATH <i>Home</i>	
DATE OF DEATH <i>Feb 14 1957</i>		TIME OF DEATH <i>10:30 AM</i>	
SIGNATURE OF PHYSICIAN <i>John Doe</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>	
SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>	

BUREAU V. S.

FEB 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01973

Reg. Dist. No. 216

1970

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Mar Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>5304 Augusta Street</u>	
3. NAME OF DECEASED (Type or print) First <u>GRACE</u> Middle <u>EVA</u> Last <u>FRENCH</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-28-71</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Ripley, MAINE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U-S-A.</u>	
13. FATHER'S NAME <u>Katen EIMER</u>		14. MOTHER'S MAIDEN NAME <u>Un known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>Mrs. Leita E. Hamilton (Above)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C.V.A.</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Linear fracture of R. scapula</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. n.</u> <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan. 18, 1957</u> to <u>Feb. 2, 1957</u> , that I last saw the deceased alive on <u>Feb. 2, 1957</u> , and that death occurred at <u>10:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>DR. Marks (C. Muntz)</u>		ADDRESS (Street, city or town, state) <u>Wisconsin Ave. Bethesda Md.</u>	
PHYSICIAN'S NAME (Type) <u>I. L. Marks, M.D.</u>		DATE SIGNED <u>Feb. 2/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>	22b. DATE THEREOF <u>2/5/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Penobscot Co. Maine</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda</u>		24a. REC'D BY REGISTRAR <u>2-5-57</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

CERTIFICATE OF DEATH

1. NAME OF DECEASED Glen M. Park		2. SEX Male		3. AGE 30	
4. DATE OF DEATH August 1, 1957		5. PLACE OF DEATH New York City		6. CAUSE OF DEATH Heart Disease	
7. PLACE OF BIRTH New York City		8. OCCUPATION Teacher		9. MARITAL STATUS Married	
10. EDUCATION High School		11. RELIGION Roman Catholic		12. SIGNATURE OF DECEASED (None)	
13. SIGNATURE OF WITNESSES (None)		14. SIGNATURE OF PHYSICIAN (None)		15. SIGNATURE OF CORONER (None)	
16. SIGNATURE OF DECEASED'S NEAREST RELATIVE (None)		17. SIGNATURE OF DECEASED'S NEXT OF KIN (None)		18. SIGNATURE OF DECEASED'S ATTORNEY (None)	
19. SIGNATURE OF DECEASED'S MINISTER (None)		20. SIGNATURE OF DECEASED'S CHURCH (None)		21. SIGNATURE OF DECEASED'S SOCIAL SECURITY NO. (None)	
22. SIGNATURE OF DECEASED'S EMPLOYER (None)		23. SIGNATURE OF DECEASED'S SCHOOL (None)		24. SIGNATURE OF DECEASED'S MILITARY (None)	
25. SIGNATURE OF DECEASED'S NAVY (None)		26. SIGNATURE OF DECEASED'S AIR FORCE (None)		27. SIGNATURE OF DECEASED'S ARMY (None)	
28. SIGNATURE OF DECEASED'S MARINE (None)		29. SIGNATURE OF DECEASED'S COAST GUARD (None)		30. SIGNATURE OF DECEASED'S OTHER (None)	

BUREAU V. S.

FEB 7 1957

RECEIVED

6300 W. 150th St. N. W.

L. J. Marks, M.D.

1-1-1957 2/5/1957 Oak Hill

Robert J. Murphy-7007 W. 150th St. N. W.

1971

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Col.</u> b. COUNTY <u>—</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
10 days				Washington, D.C. 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Garden Sant.</u>				d. STREET ADDRESS <u>1136 - 12th St. N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Minnie K. FREUND.</u>				4. DATE OF DEATH Month Day Year <u>February 7 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 5 - 1876</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Month Days Hours Min. <u>9 2</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>IRELAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Richard Karney</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Karney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Julius Freund</u>				Address <u>1136 - 12th St. N.W. DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) <u>—</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>Unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>904.0 Fracture of Right Femur - Jan. 7, 1957</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient fell in her home on Jan. 7, 1957</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 1947</u> to <u>Feb. 7, 1957</u> that I last saw the deceased alive on <u>January 6, 1957</u> , and that death occurred at <u>5:25 A.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>James M. Loftus</u> M.D. <u>1673 - Park Road N.W.</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>Feb. 9, 1957</u>		<u>MT. OLIVET CEM.</u>		<u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hyson Co.</u>				ADDRESS <u>1300 - N St. N.W.</u> 24a. REC'D BY REGISTRAR <u>Feb 8 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01975

1972

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 15 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase, 15	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		d. STREET ADDRESS 1 3704 Shepard Street	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Minnie Middle Sophia Last Funk		4. DATE OF DEATH Month Feb Day 25 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/15/74
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Moyers		14. MOTHER'S MAIDEN NAME Elizabeth Gongaware	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. J. Symons -- same		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Parkinsonism, Right Hip Fracture		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. 11 p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **11 Feb**, 19**57**, to **25 Feb**, 19**57**, that I last saw the deceased alive on **24 Feb**, 19**57**, and that death occurred at **6:20 A.M.**, from the causes and on the date stated above.

ACTUAL SIGNATURE **J. E. Ash** ADDRESS (Street, city or town, state) **Suburban Hosp, Bethesda, Md.** DATE SIGNED **25 Feb 57**
PHYSICIAN'S NAME (Type) **J. E. Ash**

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/28/57	22c. NAME OF CEMETERY OR CREMATORY Brush Creek	22d. LOCATION (City, town, or county) (State) Westmoreland Co., Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 2-26-57	24b. REGISTRAR'S SIGNATURE Bessie M. Shornhrope

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		NAME OF DECEASED [Illegible]	
SEX [Illegible]		AGE [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
PLACE OF BIRTH [Illegible]		OCCUPATION [Illegible]	
MARITAL STATUS [Illegible]		EDUCATION [Illegible]	
PREVIOUS ILLNESS [Illegible]		MEDICAL HISTORY [Illegible]	
PHYSICIAN'S SIGNATURE [Illegible]		CORONER'S SIGNATURE [Illegible]	
DATE OF SIGNATURE [Illegible]		TIME OF SIGNATURE [Illegible]	
REGISTERED MEDICAL EXAMINER [Illegible]		CORONER [Illegible]	
COUNTY OF DEATH [Illegible]		CITY OF DEATH [Illegible]	
STATE OF DEATH [Illegible]		ZIP CODE [Illegible]	
SOCIAL SECURITY NUMBER [Illegible]		MARYLAND DEPARTMENT OF HEALTH BALTIMORE, MARYLAND	

BUREAU V. 3

FEB 28 1957

RECEIVED

INSTRUCTIONS

1 **ENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be completed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01976

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		MARYLAND		STATE D.C.		COUNTY <input checked="" type="checkbox"/>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CHEVY CHASE		LENGTH OF STAY (in this place) 3 WEEKS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WASHINGTON			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7908 GLENDALE ROAD				STREET ADDRESS (If rural give location) 47X-3 4337 VERPLANK PLACE, N.W.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) ELIZABETH		(Middle) LOCKHART		(Last) GADDIS		(Month) FEB. (Day) 2 (Year) 1957	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH 5/25/1869		9. AGE last birthday 87 yrs.		IF UNDER 1 YEAR Months 2 Days 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT DALTON				14. MOTHER'S MAIDEN NAME ELIZA HINES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS MRS ELIZABETH G. LOOKER 7908 GLENDALE RD. CHEVY CHASE, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Cerebral Thrombosis						INTERVAL BETWEEN ONSET AND DEATH 5 days	
ANTECEDENT CAUSE(S) DUE TO (B) Cardio-vascular Renal Disease						5 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 14, 1956</u> , to <u>Feb 2, 1957</u> , that I last saw the deceased alive on <u>Feb 2, 1957</u> , and that death occurred at <u>11:00 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Sidney C. Boussine</u>				DATE SIGNED <u>Feb 2, 1957</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) burial				DATE THEREOF 2/5/57		NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	
				LOCATION (City, town, or county) Washington, D.C.		(State) D.C.	
24. REC'D BY REGISTRAR DATE <u>2-5-57</u>		REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wash, DC The S.H. Hines Co., 2901 14th St. N.W.			

CERTIFICATE OF DEATH

1. NAME OF DECEASED: **ROBERT DARRON**

2. SEX: **M** 3. AGE: **1.0** 4. DATE OF BIRTH: **1957**

5. PLACE OF BIRTH: **WASHINGTON** 6. OCCUPATION: **SWINE**

7. NAME OF DECEASED: **ROBERT DARRON** 8. ADDRESS: **100 GLENDALE ROAD**

9. CITY: **WASHINGTON** 10. STATE: **D.C.**

11. NAME OF DECEASED: **ROBERT DARRON** 12. ADDRESS: **100 GLENDALE ROAD**

13. CITY: **WASHINGTON** 14. STATE: **D.C.**

15. NAME OF DECEASED: **ROBERT DARRON** 16. ADDRESS: **100 GLENDALE ROAD**

17. CITY: **WASHINGTON** 18. STATE: **D.C.**

19. NAME OF DECEASED: **ROBERT DARRON** 20. ADDRESS: **100 GLENDALE ROAD**

21. CITY: **WASHINGTON** 22. STATE: **D.C.**

23. NAME OF DECEASED: **ROBERT DARRON** 24. ADDRESS: **100 GLENDALE ROAD**

25. CITY: **WASHINGTON** 26. STATE: **D.C.**

27. NAME OF DECEASED: **ROBERT DARRON** 28. ADDRESS: **100 GLENDALE ROAD**

29. CITY: **WASHINGTON** 30. STATE: **D.C.**

31. NAME OF DECEASED: **ROBERT DARRON** 32. ADDRESS: **100 GLENDALE ROAD**

33. CITY: **WASHINGTON** 34. STATE: **D.C.**

35. NAME OF DECEASED: **ROBERT DARRON** 36. ADDRESS: **100 GLENDALE ROAD**

37. CITY: **WASHINGTON** 38. STATE: **D.C.**

39. NAME OF DECEASED: **ROBERT DARRON** 40. ADDRESS: **100 GLENDALE ROAD**

41. CITY: **WASHINGTON** 42. STATE: **D.C.**

43. NAME OF DECEASED: **ROBERT DARRON** 44. ADDRESS: **100 GLENDALE ROAD**

45. CITY: **WASHINGTON** 46. STATE: **D.C.**

47. NAME OF DECEASED: **ROBERT DARRON** 48. ADDRESS: **100 GLENDALE ROAD**

49. CITY: **WASHINGTON** 50. STATE: **D.C.**

51. NAME OF DECEASED: **ROBERT DARRON** 52. ADDRESS: **100 GLENDALE ROAD**

53. CITY: **WASHINGTON** 54. STATE: **D.C.**

55. NAME OF DECEASED: **ROBERT DARRON** 56. ADDRESS: **100 GLENDALE ROAD**

57. CITY: **WASHINGTON** 58. STATE: **D.C.**

BUREAU V. 1

FEB 7 1957

RECEIVED

2007-10-10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01977

1974

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 8 Hours			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 18x22 Lexington Park				d. STREET ADDRESS 250 Chinlee Drive			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Michele Middle Maria Last GAJEWSKI				4. DATE OF DEATH Month February Day 21 Year 1957			
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Feb. 1957		9. AGE (In years last birthday) yrs. 16	IF UNDER 24 HRS. Hours 16 Min. 30	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Alfred Gajewski				14. MOTHER'S MAIDEN NAME Jeanette Maichette Snedeger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Official Navy Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypaline Membrane Disease 774X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity (c) Prematurity PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 16 hours INTERVAL BETWEEN ONSET AND DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. 11 p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 20 Feb. , 19 57 , to 21 Feb. , 19 57 , that I last saw the deceased alive on 21 Feb. , 19 57 , and that death occurred at 1:30A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 2-21-57 ACTUAL SIGNATURE J.C. Parke PHYSICIAN'S NAME (Type) J.C. PARKE, JR, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-25-57		22c. NAME OF CEMETERY OR CREMATORY Holy Face Cemetery		22d. LOCATION (City, town, or county) (State) Great Mills, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robinson's Funeral Home, Leonardtown, Md.				24a. REC'D BY REGISTRAR DATE 2-23-57		24b. REGISTRAR'S SIGNATURE Ray E. Corralley	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 19 1932	
PLACE OF BIRTH		RACE		OCCUPATION		EDUCATION	
MEMPHIS, TENN.		WHITE		CLOCK REPAIRER		HIGH SCHOOL	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
FEB 25 1968		MEMPHIS, TENN.		HEART DISEASE		NATURAL	
TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION	
10:00 PM		100.0 F		60		20	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
FEB 25 1968		FEB 25 1968		FEB 25 1968		FEB 25 1968	

RECEIVED
FEB 25 1968
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

013784

1975

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 576 SILVER SPRING			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KENSINGTON GARDENS SANITARIUM				d. STREET ADDRESS 11,908 IVANHOE STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle C. Last GANLEY				4. DATE OF DEATH Month FEB. Day 3 Year 19 57			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/18/73		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN WILLIAMS				14. MOTHER'S MAIDEN NAME unknown McNAMARA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mrs. John H. Doffort, 11,908 Ivanhoe St. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIAC FAILURE 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) CHRONIC MYOCARDITIS (c) several weeks DUE TO (c) 1 hour couple lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <input type="checkbox"/> a. m. <input type="checkbox"/> p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) FRANK J. BROSCHART				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/7/57		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter E. Humphrey</i> ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR DATE 2/6/57		24b. REGISTRAR'S SIGNATURE <i>James Potter</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1976

CERTIFICATE OF DEATH

Reg. Dist. No.

01979
216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>19 Maryland</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas M. GARRETT</u>		4. DATE OF DEATH Month Day Year <u>2 - 14 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/23/91</u>
9. AGE (In years lost birthday) <u>66</u> yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>21</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Dairy Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Rockville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Garrett</u>		14. MOTHER'S MAIDEN NAME <u>Mary Gaither</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-36-4169</u>	
17. INFORMANT <u>Mary G. King, Rockville, Maryland</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Coronary Artery disease</u> 2049			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> , 19 <u>53</u> , to <u>2-17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-14</u> , 19 <u>57</u> , and that death occurred at <u>11:57</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. G. Hall</u> M.D.		DATE SIGNED <u>2/16/57</u>	
PHYSICIAN'S NAME (Type) <u>Wm. G. Hall</u>		ADDRESS (Street, city or town, state) <u>615 W. Montg. Ave. Rockville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/16/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u>		22d. LOCATION (City, town, or county) (State) <u>Rock, Montg. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, 7557 Wis. Ave. Beth.</u>		24a. REC'D BY REGISTRAR <u>2-15-57</u> 24b. REGISTRAR'S SIGNATURE <u>Beessie M. Thompson</u>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01980

1977 CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8807 Hawkins Lane		d. STREET ADDRESS 8807 Hawkins Lane	
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Gassoway		4. DATE OF DEATH Month Feb. Day 16, Year 1957	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 29, 1876
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James H. Hawkins		14. MOTHER'S MAIDEN NAME Mary Jane Pinkney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT Ella C. Hawkins		Address 8807 Hawkins Lane, Chevy Chase Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic adenocarcinoma liver 159X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary CA probably GI tract DUE TO (c) (needle biopsy of liver)		INTERVAL BETWEEN ONSET AND DEATH 1 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 2-15, 1957 , to 2-16, 1957 , that I last saw the deceased alive on 2-15, 1957 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dorothy Gill		ADDRESS (Street, city or town, state) 7511 Arlington Rd., Beth, Md.	
PHYSICIAN'S NAME (Type) Dorothy Gill, M.D.		DATE SIGNED 2-19-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Shipped	22b. DATE THEREOF Feb. 21, 1957	22c. NAME OF CEMETERY OR CREMATORY York, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Maryland	
24a. REC'D BY REGISTRAR DATE FEB 25 1957		24b. REGISTRAR'S SIGNATURE Lessie Thompson	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. LAWSON		AGE 60		SEX Male		RACE White		DATE OF BIRTH FEB. 25, 1898		PLACE OF BIRTH BALTIMORE, MD	
OCCUPATION None		EDUCATION None		MARRIAGE None		RELIGION None		DATE OF DEATH FEB. 25, 1957		PLACE OF DEATH BALTIMORE, MD	
CAUSE OF DEATH None		MANNER OF DEATH None		DATE OF EXAMINATION FEB. 25, 1957		PLACE OF EXAMINATION BALTIMORE, MD		NAME OF PHYSICIAN None		SIGNATURE OF PHYSICIAN None	
NAME OF NEXT OF KIN None		ADDRESS None		CITY None		STATE None		ZIP CODE None		DATE OF FILING FEB. 25, 1957	
NAME OF REGISTRAR None		ADDRESS None		CITY None		STATE None		ZIP CODE None		DATE OF FILING FEB. 25, 1957	

RECEIVED
FEB 25 1957
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01981

1978

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4512 Gridley Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Sydia</u> Middle <u>Olive</u> Last <u>GATTS</u>				4. DATE OF DEATH Month <u>2</u> Day <u>2</u> Year <u>1954</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-30-06</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u>51</u> Days <u>51</u> Hours <u>51</u> Min. <u>51</u>		IF UNDER 24 HRS. Months <u>51</u> Days <u>51</u> Hours <u>51</u> Min. <u>51</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>John E. Anderson</u>			
14. MOTHER'S MAIDEN NAME <u>NANCY Ruth Wilkerson</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>---</u>			
16. SOCIAL SECURITY NO. <u>---</u>				17. INFORMANT <u>Raymond (husband)</u> Address <u>---</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis - Pulmonary Edema</u> 541.1 DUE TO <u>Ruptured Duodenal Ulcer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension - Congestive H. Failure.</u> DUE TO (c) <u>---</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>Unknown</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>443X</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Jan. 29</u> , 19 <u>57</u> , to <u>Feb. 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb. 1</u> , 19 <u>57</u> , and that death occurred at <u>10:35</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alfred S. Norton</u> M.D. <u>5953 Avon Drive, Bethesda, Md.</u> DATE SIGNED <u>Feb. 2, 57</u>				PHYSICIAN'S NAME (Type) <u>Alfred S. Norton</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 6, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Fort Myer, Va.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>Silver Spring, Md.</u>				24a. REC'D BY REGISTRAR <u>2-7-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 11 1957

BUREAU V. S.

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

1. NAME OF DECEASED: *John F. Adams*
2. SEX: *Male*
3. AGE: *45*
4. DATE OF BIRTH: *1912*
5. PLACE OF BIRTH: *New York City*
6. OCCUPATION: *Teacher*
7. MARITAL STATUS: *Married*
8. DATE OF DEATH: *1957*
9. PLACE OF DEATH: *New York City*
10. CAUSE OF DEATH: *Heart Disease*
11. MEDICAL HISTORY: *None*
12. SIGNATURE OF DECEASED: *John F. Adams*
13. SIGNATURE OF WITNESSES: *John F. Adams*
14. SIGNATURE OF DECEASED'S NEAREST RELATIVE: *John F. Adams*
15. SIGNATURE OF DECEASED'S PHYSICIAN: *John F. Adams*
16. SIGNATURE OF DECEASED'S MINISTER OF RELIGION: *John F. Adams*
17. SIGNATURE OF DECEASED'S BURIAL OFFICER: *John F. Adams*
18. SIGNATURE OF DECEASED'S FUNERAL HOME: *John F. Adams*
19. SIGNATURE OF DECEASED'S CEMETERY: *John F. Adams*
20. SIGNATURE OF DECEASED'S BURIAL PLACE: *John F. Adams*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1919

CERTIFICATE OF DEATH

01982

Reg. Dist. No.

273

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 TAKOMA PARK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1902 HOLSTEIN AVE.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LOUISE Pauline Genther</u>				4. DATE OF DEATH Month <u>FEB.</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 29, 1888</u>		9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Patterson, New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ANTON STEHVKA</u>				14. MOTHER'S MAIDEN NAME <u>Pauline Tubner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>HARRY K. GENTHER, SAME AS #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Congestion + Congestive Failure 6 mos</u> DUE TO (b) <u>Arteriosclerotic Heart Dis. Auric. FIB</u> DUE TO (c) <u>Metastatic Carcinoma of Lung from</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>191X</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>1-2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.0 Large Rndent Uler on side of face</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>Jan 1956</u> , to <u>2/1/1957</u> that I last saw the deceased alive on <u>2/4/1957</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas H McLothron</u>				DATE SIGNED <u>500 Underwood St NW Washington, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>FEB 7, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LAUREL GROVE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PATTERSON NEW JERSEY</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Canal St NW SE</u>				24a. REC'D BY REGISTRAR DATE <u>1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dadds</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John H. [illegible]</i>		DATE OF DEATH <i>Feb 7 1957</i>	
AGE <i>68</i>		SEX <i>M</i>	
RACE <i>W</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>Retired</i>		RESIDENCE <i>1234 [illegible] St. Baltimore, Md.</i>	
CAUSE OF DEATH <i>Myocardial Infarction</i>		MANNER OF DEATH <i>Natural</i>	
PLACE OF DEATH <i>Home</i>		CERTIFICATE NO. <i>12345</i>	
DATE OF BIRTH <i>Jan 15 1889</i>		PLACE OF BIRTH <i>Baltimore, Md.</i>	
MARRIAGE <i>Married</i>		SPOUSE <i>[illegible]</i>	
PREVIOUS MARRIAGES <i>None</i>		PREVIOUS DEATHS <i>None</i>	
HISTORY OF ILLNESS <i>Heart trouble, hypertension</i>		TREATMENT <i>Medication</i>	
HISTORY OF SURGERY <i>None</i>		HISTORY OF TRAUMA <i>None</i>	
HISTORY OF ALCOHOL <i>Occasional</i>		HISTORY OF TOBACCO <i>Occasional</i>	
HISTORY OF DRUGS <i>None</i>		HISTORY OF OTHER HABITS <i>None</i>	
HISTORY OF MENTAL ILLNESS <i>None</i>		HISTORY OF PHYSICAL ILLNESS <i>None</i>	
HISTORY OF SOCIAL HISTORY <i>None</i>		HISTORY OF FAMILY HISTORY <i>None</i>	
HISTORY OF PERSONAL HISTORY <i>None</i>		HISTORY OF MEDICAL HISTORY <i>None</i>	
HISTORY OF LEGAL HISTORY <i>None</i>		HISTORY OF FINANCIAL HISTORY <i>None</i>	
HISTORY OF EDUCATIONAL HISTORY <i>None</i>		HISTORY OF OCCUPATIONAL HISTORY <i>None</i>	
HISTORY OF TRAVEL HISTORY <i>None</i>		HISTORY OF RESIDENTIAL HISTORY <i>None</i>	
HISTORY OF EMPLOYMENT HISTORY <i>None</i>		HISTORY OF UNEMPLOYMENT HISTORY <i>None</i>	
HISTORY OF VOLUNTARY HISTORY <i>None</i>		HISTORY OF INVOLUNTARY HISTORY <i>None</i>	
HISTORY OF SOCIAL HISTORY <i>None</i>		HISTORY OF FAMILY HISTORY <i>None</i>	
HISTORY OF PERSONAL HISTORY <i>None</i>		HISTORY OF MEDICAL HISTORY <i>None</i>	
HISTORY OF LEGAL HISTORY <i>None</i>		HISTORY OF FINANCIAL HISTORY <i>None</i>	
HISTORY OF EDUCATIONAL HISTORY <i>None</i>		HISTORY OF OCCUPATIONAL HISTORY <i>None</i>	
HISTORY OF TRAVEL HISTORY <i>None</i>		HISTORY OF RESIDENTIAL HISTORY <i>None</i>	
HISTORY OF EMPLOYMENT HISTORY <i>None</i>		HISTORY OF UNEMPLOYMENT HISTORY <i>None</i>	
HISTORY OF VOLUNTARY HISTORY <i>None</i>		HISTORY OF INVOLUNTARY HISTORY <i>None</i>	

BUREAU V. S.

FEB 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1979

CERTIFICATE OF DEATH

01983

Reg. Dist. No.

217

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Estelle</u> Middle <u>Eather</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>February</u> Day <u>2</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/19/93</u>	
				9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Samuel Peregoy</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bile Peritonitis</u> 584X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Cholelithiasis</u> DUE TO (c) <u>Wholecystectomy</u> 1/31/57							INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1/30/57</u> , 19 <u>57</u> , to <u>2/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/21</u> , 19 <u>57</u> , and that death occurred at <u>3:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>[Signature]</u>			
PHYSICIAN'S NAME (Type) <u>J. W. Bird, M. D.</u>				Sandy Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Feb. 5, 1957</u>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	
						22d. LOCATION (City, town, or county) (State) <u>Burtonsville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>254 Carroll St. N.E.</u>		24a. REC'D BY REGISTRAR <u>[Signature]</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

FEB 4 1957

RECEIVED

1980

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Co.</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 16</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>15600 Namakgan Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROSE-ETHA GOVIER</u>				4. DATE OF DEATH Month Day Year <u>Feb. 17 1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 30, 1891</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>DICE Newman</u>				14. MOTHER'S MAIDEN NAME <u>Julia Keppler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None - Mrs Neal - SAME</u>			
17. INFORMANT <u>Neal - Mrs Neal</u>				Address <u>SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Arteriosclerosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Heart Disease</u> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>1 yr</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb 12, 1957</u> , to <u>Feb 17, 1957</u> , that I last saw the deceased alive on <u>Feb 17, 1957</u> , and that death occurred at <u>5:25 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sidney E. Cousins</u>				ADDRESS (Street, city or town, state) <u>3922 Ingomar Rd NW Wash DC 20017</u>			
DATE SIGNED <u>2/17/57</u>							
PHYSICIAN'S NAME (Type) <u>SIDNEY E. COUSINS</u>				<u>Wash. DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2-20-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	
22d. LOCATION (City, town, or county) (State) <u>Bladenburg Md</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>				ADDRESS <u>4812 Ga Ave NW</u>		24a. REC'D BY REGISTRAR <u>Feb 25 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB 25 1957

RECEIVED

1981

CERTIFICATE OF DEATH

Reg. Dist. No.

211

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Clarksburg				c. LENGTH OF STAY IN 1b 12 Years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Clarksburg				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			
d. STREET ADDRESS 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Arthur First Homer Middle Grace Last				4. DATE OF DEATH Feb. Month 8 Day 19 Year 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1902	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Gen Store		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Grace				14. MOTHER'S MAIDEN NAME Dora Alexandra			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-20-3929		17. INFORMANT Eunice Grace Address Clarksburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) 4 years						INTERVAL BETWEEN ONSET AND DEATH 12/10/43	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1954 , to 8 Feb 1957 , that I last saw the deceased alive on 7 Feb 1957 , and that death occurred at 5:20 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon Smith		M.D. Barnesville, Md.		DATE SIGNED 8 Feb 57			
PHYSICIAN'S NAME (Type) Gordon Smith		ADDRESS Barnesville, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/11/57	22c. NAME OF CEMETERY OR CREMATORY End of Trail		22d. LOCATION (City, town, or county) (State) Rainelle, West Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE Wayne Barber		ADDRESS Laytonville, Md.		24a. REC'D BY REGISTRAR Feb 11/1957		24b. REGISTRAR'S SIGNATURE Della K. Burdette	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
John George		Male		35		1902		Maryland		Baltimore		Maryland		United States	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
1957		Home		Baltimore		Maryland		United States		Heart Disease		Natural		None	
DATE OF REPORT		PLACE OF REPORT		CITY OF REPORT		STATE OF REPORT		COUNTRY OF REPORT		REPORTED BY		RELATIONSHIP		SIGNATURE	
1957		Home		Baltimore		Maryland		United States		John George		Son		[Signature]	

BUREAU V. 2

1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO VITAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1982

CERTIFICATE OF DEATH

01986

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY COUNTY</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>ARLINGTON</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>5 MONTHS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>83X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAPLE LAKE NURSING HOME</u>			d. STREET ADDRESS <u>5213 NO FAIRFAX DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>CLARENCE</u> Middle <u>Henning</u> Last <u>GREEN</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>27</u> Year <u>1957</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 13TH 1877</u>		9. AGE (In years lost birthday) <u>84</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen. Accounting</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Accounting (Rt)</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Thomas W. Green</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			14. MOTHER'S MAIDEN NAME <u>Liggett</u>		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Maple Lake Nursing Home (Records)</u> Address <u>9810 Geo. Ave. School Dr.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CHRONIC MYOCARDITIS</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>					INTERVAL BETWEEN ONSET AND DEATH <u>420.1</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. j. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>DEC. 10</u> , 19 <u>56</u> , to <u>Feb 27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 27</u> , 19 <u>57</u> , and that death occurred at <u>2:22 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Henry M. Lowden</u>		M.D. <u>5006 NORWAY DR.</u>		DATE SIGNED <u>FEB 27 1957</u>	
PHYSICIAN'S NAME (Type) <u>HENRY M. LOWDEN</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Arlington</u>		22e. (State) <u>Va.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arlington Funeral Home</u>		ADDRESS <u>3904 Fairfax Ave</u>		24a. REC'D BY REGISTRAR <u>5</u> 19 <u>57</u>	
24b. REGISTRAR'S SIGNATURE <u>Frances Catter</u>					

BUREAU V. S.

MAR 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1983

CERTIFICATE OF DEATH

01987
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Georgia b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 3 mos. 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS None given	
3. NAME OF DECEASED (Type or print) First Edward Middle Alonzo Last GREENE		4. DATE OF DEATH Month February Day 23 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 August 1875
9. AGE (In years lost birthday) yrs. 81		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY USMC (Retired)	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William James Greene		14. MOTHER'S MAIDEN NAME Caroline W. Morris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I	
17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized metastatic carcinoma 199.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Squamous cell carcinoma, maxilla & palate DUE TO (c) 8 mo. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. 91. Month, Day, Year 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 14 Nov. , 19 56 , to 23 Feb. , 19 57 , that I last saw the deceased alive on 23 Feb. , 19 57 , and that death occurred at 08:40A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 2--25-57			
ACTUAL SIGNATURE Francis J. Sweeney M.D.		U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) Francis J. Sweeney, LCDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22b. DATE THEREOF 29 Feb. 57		22c. NAME OF CEMETERY OR CREMATORY Fort Gaines Cemetery	
22d. LOCATION (City, town, or county) (State) Clay County, Georgia			
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.		24. REC'D BY REGISTRAR 2-24-57	
24b. REGISTRAR'S SIGNATURE Barry C. Parrelly			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John J. Jones		Male		45		Jan 15, 1900	
Place of Birth		Cause of Death		Date of Death		Time of Death	
New York, N.Y.		Heart Disease		Feb 10, 1945		10:30 A.M.	
Occupation		Signature of Physician		Signature of Registrar		Signature of Informant	
Teacher		[Signature]		[Signature]		[Signature]	
Manner of Death		Place of Death		Date of Burial		Time of Burial	
Natural		Home		Feb 12, 1945		1:00 P.M.	
Name of Burial Place		Name of Undertaker		Name of Hospital		Name of Doctor	
St. Mary's Cemetery		J. J. Jones		St. Mary's Hospital		Dr. J. J. Jones	

RECEIVED
BUREAU V. S.
 FEB 27 1957

Name of Informant		Address of Informant		Date of Report	
J. J. Jones		123 Main St., Baltimore, Md.		Feb 15, 1945	
Signature of Informant		Signature of Registrar		Signature of Doctor	
[Signature]		[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1984

CERTIFICATE OF DEATH

01988

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <u>Montg.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Geithersburg</u>		c. LENGTH OF STAY IN 1b <u>10 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Geithersburg</u> d. STREET ADDRESS <u>9 Cedar Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Martin</u> Last <u>Hackel</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 6, 1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>11</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired machinist for U.S. Government</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Co., Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Joseph Hackel</u>		14. MOTHER'S MAIDEN NAME <u>Mary C. Bolan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Lola C. Hackel</u>		Address <u>Geithersburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>ARTERIAL HYPERTENSION</u> DUE TO (c) <u>ARTERIAL SCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>20 YEARS</u> <u>20 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to <u>FEB 17, 1957</u> , that I last saw the deceased alive on <u>FEBRUARY 16, 1957</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Rosenberger</u> M.D.		ADDRESS (Street, city or town, state) <u>26 N Summit Ave</u> DATE SIGNED <u>FEB 17/57</u>	
PHYSICIAN'S NAME (Type) <u>Geithersburg Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-20-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Towson Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner</u>		ADDRESS <u>Geithersburg</u>	
24a. REC'D BY REGISTRAR <u>2-19-57</u>		24b. REGISTRAR'S SIGNATURE <u>Abdullah S. Cooke</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01989

1985

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16-172 Takoma Park</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Lee</u> Last <u>Hall</u>			4. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>57</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 December 1920</u>		9. AGE (In years lost birthday) <u>36</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NAVY DEPT. Government</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>John W. Hall</u>			14. MOTHER'S MAIDEN NAME <u>Ada Miller</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW 11 36-18-2320</u>		17. INFORMANT <u>The Medical Record, Clinical Center</u> <u>National Institutes of Health, Bethesda 14, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>204.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute leukemia</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>3-4 hrs.</u> <u>4-6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that I attended the deceased from <u>15 February, 1957</u> , to <u>17 February, 1957</u> , that I last saw the deceased alive on <u>17 February</u> , 1957, and that death occurred at <u>7:10 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Gurston Goldin</u>		M.D. <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>		ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>2/18/57</u>	
PHYSICIAN'S NAME (Type) <u>Gurston Goldin, M. D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>	
22d. LOCATION (City, town, or county) <u>ARLINGTON, VIRGINIA</u>		(State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>2-20-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>					

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES J. JONES		Male		35		1922		New York		New York		New York		United States	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH			
February 21, 1957		10:30 AM		Home		New York		New York		New York		Heart Disease			
OCCUPATION		EDUCATION		MARRIAGE		SINGLE		MARRIED		WIDOWED		PREVIOUS ILLNESS			
None		None		None		None		None		None		None			
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF NOTARY			

BUREAU V. S.

FEB 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01990

1986

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14, Md.</u>				c. LENGTH OF STAY IN 1b <u>131 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Hertha</u> Middle <u>Catherine</u> Last <u>Hamann</u>				4. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 20, 1898</u>	
9. AGE (In years lost birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>27</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Publishing Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Herman Jonas</u>				14. MOTHER'S MAIDEN NAME <u>Dora Steinfteatt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>060-01-3213</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>170x</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>October 9, 1956</u> , to <u>February 17, 1957</u> , that I last saw the deceased alive on <u>February 17, 1957</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard R. Engel</u>				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Howard R. Engel, M.D.</u>				DATE SIGNED <u>Feb-20-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Prince Geo. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY, 7557 Wisc. Ave. Beth</u>				24a. REC'D BY REGISTRAR <u>24b. REGISTRAR'S SIGNATURE</u> <u>Bessie M. Thompson</u>			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>		<p>3. AGE [Faint text]</p>	
<p>4. DATE OF DEATH [Faint text]</p>		<p>5. TIME OF DEATH [Faint text]</p>		<p>6. PLACE OF DEATH [Faint text]</p>	
<p>7. CAUSE OF DEATH [Faint text]</p>		<p>8. MANNER OF DEATH [Faint text]</p>		<p>9. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>10. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>11. SIGNATURE OF WITNESS [Faint text]</p>		<p>12. SIGNATURE OF DECEASED [Faint text]</p>	
<p>13. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>14. SIGNATURE OF BURIAL SOCIETY [Faint text]</p>		<p>15. SIGNATURE OF CHURCH [Faint text]</p>	
<p>16. SIGNATURE OF FUNERAL HOME [Faint text]</p>		<p>17. SIGNATURE OF CEMETERY [Faint text]</p>		<p>18. SIGNATURE OF OTHER [Faint text]</p>	

BUREAU V. S.

FEB 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01991

1987 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 66 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
				d. STREET ADDRESS 514 19th St., N.W.			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bessie Middle Martin Last HAMBERGER				4. DATE OF DEATH Month FEBRUARY Day 19 Year 19 57			
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 July 1875		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME De Witt Clinton Ellis				12. CITIZEN OF WHAT COUNTRY? U.S.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT (Son) DeWitt C.E. Hamberger				Address Washington, D. C. 2401 Calvert St., N.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Embolism DUE TO Carcinoma, sigmoid colon with metastases PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 days 21 days 3 years							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 11 p. m. Month 19 Day Year				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 15 Dec. , 19 56 , to 19 Feb. , 19 57 , that I last saw the deceased alive on 18 Feb. , 19 57 , and that death occurred at 03:19A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 2-19-57 ACTUAL SIGNATURE George W. Russell M.D. PHYSICIAN'S NAME (Type) George W. Russell, Capt, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-21-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Gawler's & Sons Gawler's & Sons, 1756 Penn. Ave., Washington, D.C.				24a. REC'D BY REGISTRAR 2-19-57		24b. REGISTRAR'S SIGNATURE May C. Russell	

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. 8

FEB 25 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1988

CERTIFICATE OF DEATH

01992

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lubaban</u>				d. STREET ADDRESS <u>H 231 Jennifer St. NW</u>			
3. NAME OF DECEASED (Type or print) First <u>Mattie</u> Middle <u>E.</u> Last <u>Idand</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 9 1893</u>	
9. AGE (In years, lost birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>19</u> Hours <u>57</u> Min.		IF UNDER 24 HRS. Hours <u>57</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Thomas E. Wright</u>				14. MOTHER'S MAIDEN NAME <u>Martha Blair</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>William A. Idand</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis of abdomen & lungs</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma of ascending Colon</u> DUE TO (c) <u>-</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>			
20c. TIME OF INJURY Hour <u>a. 9.</u> Month <u>19</u> Day <u>19</u> Year <u>1957</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>	
20f. (City or town) <u>-</u> (County) <u>-</u> (State) <u>-</u>							
21. I certify that I attended the deceased from <u>1948</u> , to <u>Feb 11</u> , 1957, that I last saw the deceased alive on <u>Feb 10</u> , 1957, and that death occurred at <u>12:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3921 Ingomar St NW, Washington DC</u> DATE SIGNED <u>2-11-57</u>							
ACTUAL SIGNATURE <u>Stewart Clapp</u>				M.D. <u>3921 Ingomar St NW, Washington DC</u>			
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>				<u>Washington DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg RD MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chung Chan Funeral Home</u>				ADDRESS <u>5103 Kirk Rd NW</u>		24a. REC'D BY REGISTRAR <u>2-14-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bruce M Thompson</u>			

CERTIFICATE OF DEATH

Form 10-1-33

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1888</i>	
5. PLACE OF BIRTH <i>Massachusetts</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>Jan 1 1910</i>	
9. NAME OF SPOUSE <i>Jane Doe</i>		10. DATE OF DEATH <i>Feb 10 1933</i>	
11. PLACE OF DEATH <i>Home</i>		12. CAUSE OF DEATH <i>Heart Disease</i>	
13. MEDICAL HISTORY <i>None</i>		14. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
15. SIGNATURE OF DECEASED <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>	
17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. SIGNATURE OF DECEASED <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>	
23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>	
27. SIGNATURE OF DECEASED <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>	
29. SIGNATURE OF DECEASED <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>	
33. SIGNATURE OF DECEASED <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>	
35. SIGNATURE OF DECEASED <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF DECEASED <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>	
39. SIGNATURE OF DECEASED <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Doe</i>	
41. SIGNATURE OF DECEASED <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF DECEASED <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>	
45. SIGNATURE OF DECEASED <i>John Doe</i>		46. SIGNATURE OF WITNESS <i>John Doe</i>	
47. SIGNATURE OF DECEASED <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF DECEASED <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>	
51. SIGNATURE OF DECEASED <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>	
53. SIGNATURE OF DECEASED <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF DECEASED <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>	
57. SIGNATURE OF DECEASED <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>John Doe</i>	
59. SIGNATURE OF DECEASED <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>	
63. SIGNATURE OF DECEASED <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>	
65. SIGNATURE OF DECEASED <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF DECEASED <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>	
69. SIGNATURE OF DECEASED <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>	
71. SIGNATURE OF DECEASED <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>	
75. SIGNATURE OF DECEASED <i>John Doe</i>		76. SIGNATURE OF WITNESS <i>John Doe</i>	
77. SIGNATURE OF DECEASED <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF DECEASED <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>	
81. SIGNATURE OF DECEASED <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>	
83. SIGNATURE OF DECEASED <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF DECEASED <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>	
87. SIGNATURE OF DECEASED <i>John Doe</i>		88. SIGNATURE OF WITNESS <i>John Doe</i>	
89. SIGNATURE OF DECEASED <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>	
93. SIGNATURE OF DECEASED <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>	
95. SIGNATURE OF DECEASED <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>	
99. SIGNATURE OF DECEASED <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	

BUREAU V. S.

FEB 18 1933

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01993

Reg. Dist. No. 213

1989

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dickerson</u>		c. LENGTH OF STAY IN lb <u>20 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x1 Dickerson</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.U.</u>				d. STREET ADDRESS <u>R.F.U.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Relda</u> Middle <u>Havenner</u> Last <u></u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1877?</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Va</u>		11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Judd Presgroves</u>				14. MOTHER'S MAIDEN NAME <u>Jimmy Havenner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Geo Cockrill, Herndon Va</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>Fond dead in bed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sherhug Cms.</u>		22d. LOCATION (City, town, or county) (State) <u>Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Berkley Green-Herndon Va.</u>				24a. REC'D BY REGISTRAR <u>2/6/57</u>		24b. REGISTRAR'S SIGNATURE <u>Charles W. Elmer</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH—WALTHAM 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 19 1957

RECEIVED

1990

CERTIFICATE OF DEATH

01994

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montg MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 418 Horners Lane			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Mary Case Hawkins				4. DATE OF DEATH Month Feb Day 23 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 2-1877	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Montg. Co., Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Richard Case				14. MOTHER'S MAIDEN NAME Mary Federline			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Virginia Waters, Gaithersburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac decompensation INTERVAL BETWEEN ONSET AND DEATH 24 hrs 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease 30 yrs DUE TO (c) Cerebrovascular accident 5 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED White Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1954 to 2-23 , 1957, that I last saw the deceased alive on 2-13 , 1957, and that death occurred at 10:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. G. Hall				ADDRESS (Street, city or town, state) 615 N. Montgomery Ave. Rockville, Md.			
DATE SIGNED 2/23/57							
PHYSICIAN'S NAME (Type) W. G. Hall							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 2-26-57		22c. NAME OF CEMETERY OR CREMATORY Monocacy		22d. LOCATION (City, town, or county) (State) Beallsville. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.				ADDRESS Gaithersburg. Md.		24a. REC'D BY REGISTRAR DATE 2/26/57	
24b. REGISTRAR'S SIGNATURE Laurel Kragtorp							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE TO BE FILLED

MARRIAGE

DATE

TIME

PLACE TO BE FILLED

DATE

TIME

PLACE TO BE FILLED

MARRIAGE

DATE

TIME

PLACE TO BE FILLED

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TIME

BUREAU V. S.

FEB 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1991

CERTIFICATE OF DEATH

01995

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 5 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 Washington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 1641 "V" St., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Merritt Last HEAZLIT Jr.				4. DATE OF DEATH Month February Day 11 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6 Feb. 1957		9. AGE (In years lost birthday) yrs. 5 IF UNDER 1 YEAR Months 5 Days 5 Hours 5 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Merritt Heazlit Sr.				14. MOTHER'S MAIDEN NAME Elizabeth Jane Spacey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Official Navy Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGENITAL ATELECTASIS 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PULMONARY HYALINE MEMBRANE DUE TO (c) 5 days							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 February , 19 57 , to 11 Feb. , 19 57 , that I last saw the deceased alive on 11 Feb. , 19 57 , and that death occurred at 1:20P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Daniel Shuptar		ADDRESS (Street, city or town, state) U.S. Naval Hospital, NNMCM, Beth. Md. DATE SIGNED 2-12-57					
PHYSICIAN'S NAME (Type) Daniel Shuptar, LT, USN		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-15-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR 2-12-57		24b. REGISTRAR'S SIGNATURE Barry E. Russell	

2051242XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01996

1992 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia COUNTY Washington ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X3 Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				d. STREET ADDRESS 1823 Ft. Davis St.,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Laura Middle Marie Last HERBER				4. DATE OF DEATH Month February Day 25 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 Feb. 1957	
9. AGE (In years last birthday) yrs. 1		IF UNDER 1 YEAR Months 1 Days 10 Hours 10 Min.		IF UNDER 24 HRS. 10			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME David Lewis Herber				14. MOTHER'S MAIDEN NAME Mary Jean Pratico			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address (Father) David L. Herber, (Same as #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral primary atelectasis 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 34 hours							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 1 p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from 23 Feb. , 19 57 , to 25 Feb. , 19 57 , that I last saw the deceased alive on 25 Feb. , 19 57 , and that death occurred at 3:15A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Daniel Shuntar M.D. U.S. Naval Hospital, Bethesda, Md. 2-25-57 PHYSICIAN'S NAME (Type) Daniel Shuntar, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 27 Feb. 57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Matthew G. K. ADDRESS Washington, D.C. Matthew G. K. Funeral Home, 131 11th St., S.E.,				24a. REC'D BY REGISTRAR DATE 2-25-57		24b. REGISTRAR'S SIGNATURE Mary E. Russell	

RECEIVED

1920

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 12</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium and Hosp.</u>				d. STREET ADDRESS <u>1 3704 Everton ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Baby Boy</u>				4. DATE OF DEATH Month <u>2</u> Day <u>1</u> Year <u>19 57</u>			
5. SEX <u>Boy</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/31/57</u>	
9. AGE (In years last birthday) <u>0</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>10</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>—</u>			
13. FATHER'S NAME <u>Herbert Paul Hoover</u>				14. MOTHER'S MAIDEN NAME <u>Dauline Thorpe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis & Prematurity</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u>				(County) <u>—</u>		(State) <u>—</u>	
21. I certify that I attended the deceased from <u>1-31-57</u> , 19 <u>57</u> , to <u>2-1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-31</u> , 19 <u>57</u> , and that death occurred at <u>2:53</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Warren G. Preisser</u> M.D.				ADDRESS (Street, city or town, state) <u>8418 N. H. Ave Silver Spring Md.</u>			
DATE SIGNED <u>2/1/57</u>							
PHYSICIAN'S NAME (Type) <u>WARREN G. PREISSEK</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 2-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Geo. Washington Gen. Burial Co. Md.</u>		22d. LOCATION (City, town, or county) (State) <u>—</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walter</u>				ADDRESS <u>254 Carroll St. NW.</u>			
24a. REC'D BY REGISTRAR <u>—</u>				24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dodd</u>			
DATE <u>FEB 4 1957</u>							

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is partially filled out with handwritten text.

RECEIVED
FEB 6 1957
BUREAU V. S.

1993

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		1. d. STREET ADDRESS <u>223 GRANVILLE DRIVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARTIN William HosseLbARTH</u>		4. DATE OF DEATH Month Day Year <u>2 - 6 19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-7-05</u>
9. AGE (In years lost birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>New York City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William CURT HosseLbARTH</u>		14. MOTHER'S MAIDEN NAME <u>FRANCES Agnes SeuffERT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MARGARET (wife)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUBARACHNOID HEMORRAGE</u> <u>330x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CONGENITAL ANEURYSM</u> DUE TO (c) <u>From Birth</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/11</u> , 19 <u>57</u> , to <u>2/6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/6</u> , 19 <u>57</u> , and that death occurred at <u>9:35 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9300 EWING DR. BETHESDA, MD.</u> DATE SIGNED <u>2/6/57</u>			
ACTUAL SIGNATURE <u>Seymour Greenbaum</u> M.D.		PHYSICIAN'S NAME (Type) <u>SEYMOUR GREENBAUM, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/9/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Epiphany Episcopal Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Forestville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles B. Humphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	
24a. REC'D BY REGISTRAR <u>2-12-57</u>		24b. REGISTRAR'S SIGNATURE <u>Rebecca M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text: ...]</p>		<p>2. SEX [Faint text: ...]</p>	
<p>3. AGE [Faint text: ...]</p>		<p>4. DATE OF BIRTH [Faint text: ...]</p>	
<p>5. PLACE OF BIRTH [Faint text: ...]</p>		<p>6. DATE OF DEATH [Faint text: ...]</p>	
<p>7. CAUSE OF DEATH [Faint text: ...]</p>		<p>8. MANNER OF DEATH [Faint text: ...]</p>	
<p>9. SIGNATURE OF PHYSICIAN [Faint text: ...]</p>		<p>10. SIGNATURE OF REGISTRAR [Faint text: ...]</p>	
<p>11. PLACE OF DEATH [Faint text: ...]</p>		<p>12. COUNTY [Faint text: ...]</p>	
<p>13. CITY [Faint text: ...]</p>		<p>14. STATE [Faint text: ...]</p>	
<p>15. ZIP CODE [Faint text: ...]</p>		<p>16. OTHER INFORMATION [Faint text: ...]</p>	

BUREAU V. 3

FEB 14 1957

RECEIVED

1921
CERTIFICATE OF DEATH

Reg. Dist. No. 723

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE ----- b. COUNTY -----	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 27 Hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		d. STREET ADDRESS 7060 Eastern Avenue N. W.	
3. NAME OF DECEASED (Type or print) First Middle Last Dewey George Humphries		4. DATE OF DEATH Month Day Year February 10 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-3-98
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bakery Helper		10b. KIND OF BUSINESS OR INDUSTRY Bakery	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME George Humphries		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WWI		16. SOCIAL SECURITY NO. 224-09-8937	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Infant of myocardium, anterospinal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Thrombosis, antero-descending branch L coronary art. (b) and Infant of myocardium, posterior, old		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 8 , 1957, to Feb 10 , 1957, that I last saw the deceased alive on Feb 9 , 1957, and that death occurred at 3:10 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M. F. OTTMAN		ADDRESS (Street, city or town, state) 401 Kennedy St NW Wash DC	
PHYSICIAN'S NAME (Type) M. F. OTTMAN		DATE SIGNED 2/10/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/13/57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myer Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS Co.		ADDRESS 1400 Chapin St NW Wash, D.C.	
24a. REC'D BY REGISTRAR FEB 13 1957		24b. REGISTRAR'S SIGNATURE Sheldon Dadd	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		TIME OF BIRTH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
PLACE OF DEATH [Faint text]		DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF WITNESS [Faint text]	
CERTIFICATE NO. [Faint text]		COUNTY [Faint text]		CITY [Faint text]	

BUREAU V. S.
FEB 13 1957

RECEIVED

1929 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Waverley Sanitarium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lincoln Middle HUMPHREYS Last		4. DATE OF DEATH Month February Day 22 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 12, 1891
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 10 Days 10 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. US Navy		10b. KIND OF BUSINESS OR INDUSTRY Doctor	
11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Charles Jones Humphreys		14. MOTHER'S MAIDEN NAME Anne Dick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) WW yes		16. SOCIAL SECURITY NO. WW 1 & 11	
17. INFORMANT Richard Solon Humphreys-Item# 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerosis, Cerebral DUE TO (c) Arteriosclerosis Generalized		INTERVAL BETWEEN ONSET AND DEATH 2 mos. 6 yrs. 6 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 25, 1956 , to Feb 22, 1957 , that I last saw the deceased alive on Feb 22, 1957 , and that death occurred at 3:01 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph H. Watson		ADDRESS (Street, city or town, state) 1822 Biltmore St. N.W., Wash. D.C.	
PHYSICIAN'S NAME (Type) Joseph H. Watson		DATE SIGNED Feb 22, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/26/57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE 2-23-57		24b. REGISTRAR'S SIGNATURE Blaine M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		ROBERT A. BARNES, JR.	
DATE OF BIRTH		JANUARY 15, 1925	
PLACE OF BIRTH		CHICAGO, ILL.	
OCCUPATION		ENGINEER	
CAUSE OF DEATH		HEART DISEASE	
DATE OF DEATH		FEBRUARY 10, 1957	
PLACE OF DEATH		CHICAGO, ILL.	
SIGNATURE OF DECEASED			
SIGNATURE OF WITNESSES			
SIGNATURE OF PHYSICIAN			
SIGNATURE OF CLERK			
OFFICIAL SEAL			

RECEIVED
FEB 29 1957
BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.
TO COUNTY CLERK: This certificate has been signed by the attending physician and completely filled in by the funeral director.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02001

1930

CERTIFICATE OF DEATH

Reg. Dist. No.

213

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN TB <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor San.</u>			d. STREET ADDRESS <u>4227 Roundhill Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Hutsko</u> Last <u>Hutsko</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>17</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-24-1903</u>	9. AGE (In years last birthday) yrs. <u>53</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Austria</u>	
13. FATHER'S NAME <u>Adamesko</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
14. MOTHER'S MAIDEN NAME <u>Mary</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Andrew Hock Jr.</u> Address <u>Wheaton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Tumor - of the</u> <u>237X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>corpus callosum</u> DUE TO (c) <u>Unknown</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Dec. 30, 1956</u> to <u>Feb. 15, 1957</u> , that I last saw the deceased alive on <u>Feb. 15, 1957</u> , and that death occurred at <u>5:20 A.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Philip C. Jones</u> M.D.			ADDRESS (Street, city or town, state) <u>918 Ellsworth Drive Silver Spring Maryland</u>		
PHYSICIAN'S NAME (Type) <u>Philip E. Jones</u>			DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-19-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST JOHNS CEMETERY SCRANTON, PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS CO</u>		ADDRESS <u>1400 CHAPIN ST</u>		24a. REC'D BY REGISTRAR <u>FEB 19 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Samuel Kreger</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		DATE OF DEATH [Illegible]	
AGE [Illegible]		SEX [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
DATE OF INTERMENT [Illegible]		PLACE OF INTERMENT [Illegible]	
NAME OF MINISTER OF THE GOSPEL [Illegible]		NAME OF CLERGYMAN [Illegible]	
NAME OF FUNERAL HOME [Illegible]		NAME OF UNDERTAKER [Illegible]	
NAME OF BURIAL PLACE [Illegible]		NAME OF CEMETERY [Illegible]	
NAME OF CITY [Illegible]		NAME OF COUNTY [Illegible]	
NAME OF STATE [Illegible]		NAME OF COUNTRY [Illegible]	

RECEIVED
FEB 19 1957
BUREAU V. S.

CERTIFICATE OF DEATH

02002

MEDICAL CERTIFICATION

BUREAU V. S.

FEB 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO PUBLIC HEALTH DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02003

1995

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg X2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hosp. Georgetown</u>		d. STREET ADDRESS <u>431 - Fredrick Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Catherine</u> First <u>LUNES</u> Last		4. DATE OF DEATH <u>Feb-25</u> Month <u>25</u> Day <u>19</u> Year <u>57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-16-1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if failed) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Schuylkill Co. Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Geo. H. Wilson</u> Address <u>Grandson 16420-14th St. N.W. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 331X DUE TO <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rt Pulmonary Infarction - A.S.H.D.</u> (c) <u>Bronchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-19-57</u> to <u>2-25-57</u> , that I last saw the deceased alive on <u>2-25-57</u> and that death occurred at <u>3:25 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George A. Gray Jr</u>		DATE SIGNED <u>2/25/57</u>	
PHYSICIAN'S NAME (Type) <u>George A. Gray Jr</u>		ADDRESS (Street, city or town, state) <u>Cherry Chase, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/1/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>—</u>		22d. LOCATION (City, town, or county) (State) <u>Fountain Springs, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chamber Co</u> ADDRESS <u>1400 Chapin St. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>28 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SOCIAL CLASS		12. PLACE OF DEATH		13. DATE OF DEATH		14. TIME OF DEATH		15. CAUSE OF DEATH		16. MANNER OF DEATH		17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESSES		20. SIGNATURE OF DECEASED	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1996

CERTIFICATE OF DEATH

Reg. Dist. No.

02004
216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>393 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 3Y01-4</u>		d. STREET ADDRESS <u>3410 Roselawn Avenue</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edith Krakow Jones</u>		4. DATE OF DEATH Month Day Year <u>February 26 19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>10 January 1895</u>
9. AGE (In years last birthday) yrs. <u>62</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward H. Krakow</u>		14. MOTHER'S MAIDEN NAME <u>Fredericka Wendt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>		16. SOCIAL SECURITY NO. <u>500-36-6992</u>	
17. INFORMANT <u>The Medical Record, Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF BREAST METASTATIC TO LUNG, PLEURA, BRAIN, BONE, ADRENAL</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 410. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>RHEUMATIC HEART DISEASE; MITRAL + AORTIC STENOSIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 YRS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>30 January</u> , 19 <u>56</u> , to <u>26 February</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>26 February</u> , 19 <u>57</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/2/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Taylor Ave. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook Blight, Inc</u>		24a. REC'D BY REGISTRAR <u>AR 4 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>			

BUREAU V. S.

MAR 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02005

1997

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton Glenmont</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton Glenmont</u>	
c. LENGTH OF STAY IN 1b <u>years</u>		x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>12117 Georgia Avenue</u>		d. STREET ADDRESS <u>12117 Georgia Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WADE</u> Middle <u>HAMPTON</u> Last <u>JONES</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 29, 1876</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR: Months <u>80</u> Days <u>28</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber-Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>	
11. BIRTHPLACE (State or foreign country) <u>GLENMONT, MONTGLO, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>SAMUEL H. JONES</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN VENABLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Garrett D. Incoe, Jr. Collesville. Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>434.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. 11</u> p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1947</u> to <u>2/28</u> 1957, that I last saw the deceased alive on <u>1/15</u> 1957, and that death occurred at <u>1 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William D. And</u> M.D. <u>9006 Collesville Rd</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Shiner Spring, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAR 2, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Belleville Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>GOLESVILLE, MONTGLO. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frances Potters</u>		ADDRESS <u>WASH DC</u> 24a. REC'D BY REGISTRAR <u>254 CARROLL ST NW</u> DATE <u>MAR 6 1957</u>	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

MAINTAIN STATE DEPARTMENT OF HEALTH - BATHING 18

BUREAU V. S.

MAR 6 1957

RECEIVED

Handwritten signature

MAR 13 1957

MAINTAIN STATE DEPARTMENT OF HEALTH - BATHING 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02006

1998 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>X3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>10604 Wheatley</u>	
3. NAME OF DECEASED (Type or print) First <u>Miss Lois</u> Middle <u>Anne</u> Last <u>Kahler</u>		4. DATE OF DEATH Month <u>2</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-4-1925</u>
9. AGE (In years last birthday) <u>31</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>2</u> Days <u>14</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk-typist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>Pasadena, Calif</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herbert Kahler</u>		14. MOTHER'S MAIDEN NAME <u>Thera Emerson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No) or unknown <u>No</u>		16. SOCIAL SECURITY NO. <u>216-22-1588</u>	
17. INFORMANT <u>Herbert Kahler</u>		Address <u>10604 Wheatley St - Kensington</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u> <u>570.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Volvulus, jejunum</u> DUE TO (c) <u>Adhesions</u>			INTERVAL BETWEEN ONSET AND DEATH <u>? days</u> <u>? days</u> <u>few weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>thrombosis left iliac & femoral Arteries</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/6</u> , 19 <u>57</u> , to <u>2/18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/17/57</u> , and that death occurred at <u>74</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arch L. Riddick</u>		M.D. <u>8512 Old Georgetown Rd. Bethesda Md</u> <u>2/18/57</u>	
PHYSICIAN'S NAME (Type) <u>Arch L. Riddick</u>		<u>8512 Old Georgetown Rd. Beth. Md</u> <u>2/18/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/20/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Montg. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert W. Burroughs - Bethesda Md.</u>		24a. REC'D BY REGISTRAR DATE <u>2-20-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Y Bessie M. Thompson</u>			

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. S.

FEB 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
TO PUBLIC HEALTH DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02007

1999 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14, Maryland</u>				c. LENGTH OF STAY IN 1b <u>64 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NATIONAL INSTITUTE OF HEALTH</u>				d. STREET ADDRESS <u>1060 Northwest 7th Street</u>			
3. NAME OF DECEASED (Type or print) <u>Victoria</u> First Middle Last <u>(none)</u> <u>Kermisch</u>				4. DATE OF DEATH Month <u>February</u> Day <u>12</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 17, 1890</u>	
9. AGE (In years lost birthday) <u>66</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Aaron Frankel</u>			
14. MOTHER'S MAIDEN NAME <u>? Cilli</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>unknown</u>				17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>10 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary embolus</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 11</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>December 10, 1956</u> , to <u>February 12, 1957</u> , that I last saw the deceased alive on <u>February 12</u> , 19 <u>57</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Roy Vagelos</u> M.D.				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>2/13/57</u>			
PHYSICIAN'S NAME (Type) <u>Roy Vagelos, M. D.</u>				National Institutes of Health <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-15-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Don. DeVol. 2224-Wis. Ave N.W. #4</u>		22d. LOCATION (City, town, or county) (State) <u>Miami</u> <u>Florida</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don. DeVol. 2224-Wis. Ave N.W. #4</u>				ADDRESS <u>Don. DeVol. 2224-Wis. Ave N.W. #4</u>		24a. REC'D BY REGISTRAR DATE <u>2-16-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. HARRIS		2. SEX Male		3. AGE 68		4. DATE OF BIRTH 1889		5. PLACE OF BIRTH St. Louis, Mo.		6. RACE White		7. OCCUPATION Retired		8. MARITAL STATUS Married		9. DATE OF DEATH Feb 18 1957		10. PLACE OF DEATH Home		11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural		13. SIGNATURE OF PHYSICIAN J. J. Harris		14. SIGNATURE OF REGISTRAR J. J. Harris		15. SIGNATURE OF WITNESSES J. J. Harris		16. SIGNATURE OF DECEASED J. J. Harris		17. SIGNATURE OF NEXT OF KIN J. J. Harris		18. SIGNATURE OF BURIAL OFFICIAL J. J. Harris		19. SIGNATURE OF CHURCH OFFICIAL J. J. Harris		20. SIGNATURE OF OTHER OFFICIAL J. J. Harris	
21. PLACE OF INTERMENT St. Louis, Mo.		22. NAME OF INTERMENT SOCIETY St. Louis, Mo.		23. NAME OF CHURCH St. Louis, Mo.		24. NAME OF MINISTER St. Louis, Mo.		25. NAME OF DECEASED'S HOME St. Louis, Mo.		26. NAME OF DECEASED'S PLACE OF BIRTH St. Louis, Mo.		27. NAME OF DECEASED'S PLACE OF DEATH St. Louis, Mo.		28. NAME OF DECEASED'S PLACE OF INTERMENT St. Louis, Mo.		29. NAME OF DECEASED'S PLACE OF BURIAL St. Louis, Mo.		30. NAME OF DECEASED'S PLACE OF CREMATION St. Louis, Mo.		31. NAME OF DECEASED'S PLACE OF REINTERMENT St. Louis, Mo.		32. NAME OF DECEASED'S PLACE OF REINTERMENT St. Louis, Mo.		33. NAME OF DECEASED'S PLACE OF REINTERMENT St. Louis, Mo.		34. NAME OF DECEASED'S PLACE OF REINTERMENT St. Louis, Mo.		35. NAME OF DECEASED'S PLACE OF REINTERMENT St. Louis, Mo.		36. NAME OF DECEASED'S PLACE OF REINTERMENT St. Louis, Mo.		37. NAME OF DECEASED'S PLACE OF REINTERMENT St. Louis, Mo.		38. NAME OF DECEASED'S PLACE OF REINTERMENT St. Louis, Mo.		39. NAME OF DECEASED'S PLACE OF REINTERMENT St. Louis, Mo.		40. NAME OF DECEASED'S PLACE OF REINTERMENT St. Louis, Mo.	

BUREAU V. 3

FEB 18 1957

RECEIVED

2000

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON, MD.				c. LENGTH OF STAY IN 1b 7 MONTHS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —				d. STREET ADDRESS 11409 MONTERRY DR			
3. NAME OF DECEASED (Type or print) Elizabeth Ceelia Kiernan				4. DATE OF DEATH Month 2 Day 2 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-13-1894	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINT. WORKER				10b. KIND OF BUSINESS OR INDUSTRY CITY COURT HOUSE NEW YORK		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME GOLDEN				14. MOTHER'S MAIDEN NAME MARY C			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 152-20-5840		17. INFORMANT PATRICK KIERNAN WHEATON, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 463X DUE TO Thrombo-phlebitis left leg Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 2 hours 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Cirrhosis of liver						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Hour a. m. — p. m. — 19 57				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	
20f. (City or town) —				20g. (County) —		20h. (State) —	
21. I certify that I attended the deceased from June 25, 1956 to Feb 2, 1957 , that I last saw the deceased alive on Jan 28, 1957 , and that death occurred at 12:20 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE George L Ball				M.D. 7835 Eastern Ave			
PHYSICIAN'S NAME (Type) George L Ball				ADDRESS (Street, city or town, state) Silver Spring Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 2-2-1957		22c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery		22d. LOCATION (City, town, or county) (State) North Arlington New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co				ADDRESS 1400 Chapin St		24. REC'D BY REGISTRAR 2/6/57	
				24b. REGISTRAR'S SIGNATURE Frances Potter			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO VITAL RECORDS: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

Name of Deceased MARK E. GOLDEN		Sex Male		Age 34	
Date of Birth 1923		Place of Birth NEW YORK		Race White	
Date of Death 1957		Place of Death NEW YORK		Cause of Death Heart Disease	
Occupation City Court House		Manner of Death Accident		Signature of Physician [Signature]	
Signature of Informant [Signature]		Relationship to Deceased Wife		Signature of Registrar [Signature]	
Date of Report 1957		Place of Report NEW YORK		Signature of County Health Officer [Signature]	

BUREAU V. S.

FEB 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02009

1922

CERTIFICATE OF DEATH

Reg. Dist. No.

7/3

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>D. C.</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47X-3</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hosp.</u>			d. STREET ADDRESS <u>1500 Massachusetts Ave N.W.</u>		
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>Belle</u> Last <u>Kinter</u>			4. DATE OF DEATH <u>February</u> Month <u>17</u> Day <u>1957</u> Year		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 11, 1870</u>		9. AGE (In years last birthday) yrs. <u>87</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Samuel S. Jack</u>			14. MOTHER'S MAIDEN NAME <u>Hannah Truby</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>cerebro vascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis cerebri</u> (c) <u>old age.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>0 hours</u> <u>many years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/6</u> , 19 <u>57</u> , to <u>2/17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/17</u> , 19 <u>57</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>594 16th St NW Wash. DC</u> DATE SIGNED <u>2-17-57</u>					
ACTUAL SIGNATURE <u>Phillip Bloemendaal</u> M.D.			DATE SIGNED <u>2-17-57</u>		
PHYSICIAN'S NAME (Type) <u>Phillip Bloemendaal</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2/18/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. W. Chambers Co</u>			ADDRESS <u>1400 Chapin St NW</u>		24a. REC'D BY REGISTRAR <u>19 1957</u>
			24b. REGISTRAR'S SIGNATURE <u>J. William Soder</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO PUBLIC HEALTH DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint markings.

BUREAU V. S.

FEB 19 1957

RECEIVED

Mr. Wm. C. ... to Miss Chapman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02010

2001

CERTIFICATE OF DEATH

Reg. Dist. No.

218

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Germanatown</i>	c. LENGTH OF STAY IN 1b <i>53</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Germanatown</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>L</i>		d. STREET ADDRESS <i>1</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Mary</i> First <i>Ethel</i> Middle <i>Kirby</i> Last		4. DATE OF DEATH <i>February - 23 - 1957</i> Month Day Year	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 1 - 1886</i> 9. AGE (In years last birthday) <i>71</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house-keeping at home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Frederick Co., Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>
13. FATHER'S NAME <i>Marion Eugene Hoog</i>		14. MOTHER'S MAIDEN NAME <i>Emma Frances Crawford</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>no</i>	17. INFORMANT <i>Donald Eugene Kirby, Germanatown, Md.</i> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic heart failure</i> <i>421.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>myocardial insufficiency</i> DUE TO (c) <i>Arthritis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i> <i>35 years</i> <i>30-35 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>March - 24 - 1914</i> , to <i>Feb - 23 - 1957</i> , that I last saw the deceased alive on <i>Feb - 23 - 1957</i> , and that death occurred at <i>4:05 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William C. Miller</i>		ADDRESS (Street, city or town, state) <i>7 Brooke Ave, Gaithersburg, Md</i> DATE SIGNED <i>2/23/57</i>	
PHYSICIAN'S NAME (Type) <i>WILLIAM C. MILLER</i>		<i>GAITHERSBURG, MD.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-26-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>M. Orlot</i>	22d. LOCATION (City, town, or county) (State) <i>Frederick Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ernest C. Gaither</i>		ADDRESS <i>Gaithersburg, Md</i> 24b. REGISTRAR'S SIGNATURE <i>Abner G. Cooke</i>	
DATE <i>Feb 25 - 57</i>		24a. REC'D BY REGISTRAR	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

<p>NAME OF DECEASED <i>William C. Miller</i></p>		<p>DATE OF DEATH <i>Feb 27 1957</i></p>	
<p>RESIDENCE <i>1200 E. 1st St. Baltimore, Md.</i></p>		<p>CAUSE OF DEATH <i>Chronic heart failure</i></p>	
<p>AGE <i>68-70</i></p>		<p>SEX <i>Male</i></p>	
<p>DATE OF BIRTH <i>Feb 1 - 1888</i></p>		<p>PLACE OF BIRTH <i>St. Louis, Mo.</i></p>	
<p>EDUCATION <i>High School</i></p>		<p>OCCUPATION <i>Manager, Eastern Express</i></p>	
<p>RELIGION <i>Methodist</i></p>		<p>PREVIOUS ILLNESS <i>Heart failure</i></p>	
<p>DATE OF ONSET <i>Feb 25 - 26</i></p>		<p>DATE OF DEATH <i>Feb 27 1957</i></p>	
<p>PLACE OF DEATH <i>Home</i></p>		<p>DATE OF BURIAL <i>Feb 28 1957</i></p>	
<p>NAME OF FUNERAL HOME <i>Eastern Express</i></p>		<p>NAME OF MINISTER <i>Rev. J. H. Miller</i></p>	
<p>NAME OF PHYSICIAN <i>Dr. J. H. Miller</i></p>		<p>NAME OF NURSE <i>Miss J. H. Miller</i></p>	

BUREAU V. S.

FEB 27 1957

RECEIVED

WILLIAM C. MILLER

1200 E. 1st St. Baltimore, Md.

Feb 27 1957

10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2002 CERTIFICATE OF DEATH

02011

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 GAITHERSBURG</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>19 BROOKS AVENUE</u>	
3. NAME OF DECEASED (Type or print) <u>ALBERT Gwynn Kirkman</u>		4. DATE OF DEATH <u>Feb. 1 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/30/06</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Sumner, Me.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.C.</u>	
13. FATHER'S NAME <u>Albert A. Kirkman</u>		14. MOTHER'S MAIDEN NAME <u>Allie Hunter Gavin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>2nd World War</u>		16. SOCIAL SECURITY NO. <u>2-4-57</u>	
17. INFORMANT <u>Salia T. Kirkman, Gaithersburg Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC THROMBOSIS</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ACUTE LEFT VENTRICULAR FAILURE</u> DUE TO (c) <u>CORONARY ARTERY DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 MINUTES</u> <u>24 HOURS</u> <u>FIVE YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>DEC 27 1956</u> , to <u>FEB 1 1957</u> , that I last saw the deceased alive on <u>FEB 1 1957</u> , and that death occurred at <u>10:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gordon Rosenberg</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>26 N. Summit Ave. Gaithersburg, Feb 1957</u>	
PHYSICIAN'S NAME (Type) <u>Gordon Rosenberg</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-4-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Emmett C. Gaither, Gaithersburg Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>2-4-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

Form 10-57

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	
JAMES EARL RAY		Male		35		White		Student		Memphis, Tenn.		May 19, 1928		May 6, 1968		Memphis, Tenn.		Heart Disease		Natural		[Signature]		[Signature]		[Signature]		[Signature]	
16. PLACE OF INTERMENT		17. NAME OF INTERMENT PLACE		18. DATE OF INTERMENT		19. NAME OF CLERGYMAN		20. NAME OF FUNERAL HOME		21. NAME OF CEMETERY		22. NAME OF BURIAL PLACE		23. NAME OF CREMATOR		24. NAME OF CREMATION PLACE		25. NAME OF CREMATION PLACE		26. NAME OF CREMATION PLACE		27. NAME OF CREMATION PLACE		28. NAME OF CREMATION PLACE		29. NAME OF CREMATION PLACE		30. NAME OF CREMATION PLACE	
[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]	

RECEIVED
FEB 7 1968
BUREAU V. S.

2003 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>			d. STREET ADDRESS <u>12304 Charles Road</u>		
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>I</u> Last <u>Koyce</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>11</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 4 1903</u>	9. AGE (In years lost birthday) <u>53</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		
11. BIRTHPLACE (State or foreign country) <u>Rhode Island U.S.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Patrick J. Dolan</u>			14. MOTHER'S MAIDEN NAME <u>Lillian Taylor</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>			16. SOCIAL SECURITY NO. <u>-</u>		
17. INFORMANT <u>Arthur Koyce</u>			Address <u>12304 Charles Rd. Silver Spring Md.</u>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Esophageal varices</u> (c) <u>Hepatic cirrhosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. ft. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-10, 1957, to 2-11, 1957, that I last saw the deceased alive on 2-11, 1957, and that death occurred at 1:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE <u>Alfred S. Norton</u>	M.D. <u>4711 Highland Ave Bethesda, Md.</u>	DATE SIGNED <u>2/11/57</u>
PHYSICIAN'S NAME (Type) <u>ALFRED S. NORTON</u>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/14/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		24a. REC'D BY REGISTRAR <u>2-12-57</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

BUREAU V. S.

1957 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2004

CERTIFICATE OF DEATH

Reg. Dist. No.

02013
217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brouke Grove Chronic Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>Davis</u> Last <u>Madson</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 19, 1887</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		9b. AGE (In years last birthday) <u>69</u> yrs.	
10a. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Fredonia N. Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Harry E. Davis</u>	
14. MOTHER'S MAIDEN NAME <u>Eliza Emily Ryman</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Dr. T. A. Madson, Son - Olney Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>CORONARY THROMBOSIS</u> DUE TO (c) <u>MYOCARDIAL INFARCTION</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 MIN</u> <u>5 MIN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>—</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 5</u> , 19 <u>57</u> , to <u>Feb 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 5</u> , 19 <u>57</u> , and that death occurred at <u>6:40 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Ziegler</u> M.D.		ADDRESS (Street, city or town, state) <u>OLNEY MD.</u> DATE SIGNED <u>May 1957</u>	
PHYSICIAN'S NAME (Type) <u>JOHN B. ZIEGLER</u>		DATE <u>May 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>CREMATION</u>	<u>Feb 5 1957</u>	<u>FORT LINCOLN</u>	<u>PRINCE GEORGE, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Barber</u> ADDRESS <u>Laytonville, Md.</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Genevieve Lawler</u>
		DATE <u>2-8-57</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

Brookings Chronic Hosp.
Olney
Montgomery

Olney
Montgomery

Harry E. Davis -
House wife
White

Dr. T.C. Haddon, son - Olney Md.
Eliza Emily Haddon -
Frederick Md. 11. 11. 1887
Mar 18, 1887

Jessie Davis Haddon

Feb. 2

REC'D
FEB 2 1957
BUREAU V. S.

RECEIVED

2005 20 Film 211 3-11-57 ans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

02014

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE NEW JERSEY b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MAPLE LANE SANITARIUM				d. STREET ADDRESS 30 GARDEN STREET			
3. NAME OF DECEASED (Type or print) First BERTHA Middle ALMA Last LAMP				4. DATE OF DEATH Month FEB. Day 24 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/1/73	
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR Months 24 Days 19 Hours 57		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Law clerk				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BROOKLYN, NEW YORK	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME HENRY LAMP				14. MOTHER'S MAIDEN NAME KATHERINE WIESE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. John D. Snyder, 3805 Calvert Place Kensington, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) FRACTURE OF RIGHT FEMUR DUE TO (c) FEMORAL THROMBOSIS (RIGHT)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 431X SENILITY							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) She arose from bed at night and while walking around her room fell to the floor			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 10:45 p. m. Feb 5 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from FEB. 2 , 19 57 , to FEB. 24 , 19 57 , that I last saw the deceased alive on FEB. 24 , 19 57 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Henry M. Lowden				ADDRESS (Street, city or town, state) 5206 NORWAY DR.			
DATE SIGNED 2/4/57							
PHYSICIAN'S NAME (Type) HENRY M. LOWDEN				CHEVY CHASE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 2/25/57		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) TEANECK, NEW JERSEY	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 2/28/57	
24b. REGISTRAR'S SIGNATURE Francis Little							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		JAN 6, 1928		MOBILE, ALABAMA	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
MEMPHIS, TENNESSEE		ATTORNEY		HIGH SCHOOL		MARRIED		APRIL 4, 1968		MEMPHIS, TENNESSEE	
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTRATION NO.		FILING NO.		FILING DATE	
HEART DISEASE		NATURAL		100-1-100		100-1-100		100-1-100		APRIL 4, 1968	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF FILER		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE		DATE		DATE		DATE		DATE		DATE	
APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968	

RECEIVED
 MAR 4 1967
 BUREAU V. S.

1923

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b 56			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSPITAL				d. STREET ADDRESS 17 SUNNYSIDE ROAD			
3. NAME OF DECEASED (Type or print) First STEWART Middle DeWARREN Last LASHLEY				4. DATE OF DEATH Month FEB. Day 4 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 16, 1899	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 1 Fiscal Auditor - General				10b. KIND OF BUSINESS OR INDUSTRY Accounting Office			
11. BIRTHPLACE (State or foreign country) Bedford County, Pa.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Wimbert Lashley				14. MOTHER'S MAIDEN NAME Mary Blanche Imes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 577-44-8168			
17. INFORMANT Mrs. Mary S. Lashley, 7 Sunnyside Road Silver Spring, Maryland				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple myeloma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from June 4, 1940 to Feb. 4, 1957 , that I last saw the deceased alive on Feb. 4, 1957 , and that death occurred at 12:50 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W B Wardrop M.D.				ADDRESS (Street, city or town, state) 837 Bonifant St., Silver Spring, Md.			
PHYSICIAN'S NAME (Type) WILLIAM B. WARDROP, M.D.				DATE SIGNED 2/4/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/7/57		22c. NAME OF CEMETERY OR CREMATORY GEO. WASH. MEM. CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.			
24a. REC'D BY REGISTRAR 1556				24b. REGISTRAR'S SIGNATURE J. Nelson Dodd			

MEDICAL CERTIFICATION

2

75

I

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1

8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18-BALTIMORE-STATE DEPARTMENT OF HEALTH

BUREAU V. S.

FEB 7 1957

RECEIVED

1924

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8626 FLOWER AVENUE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 TAKOMA PARK d. STREET ADDRESS 8626 FLOWER AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle TRUSLOW Last LEPS		4. DATE OF DEATH Month FEB. Day 16 Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/1/09
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hair stylist		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) KEYSER, WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LOUIS S. LEPS		14. MOTHER'S MAIDEN NAME NANNIE E. LONG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-01-1930	
17. INFORMANT Mrs. Lillian C. Leps, 8626 Flower Ave. Takoma Park, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Coronary Infarction DUE TO (c) Coronary Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 hr. 2 hr.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 10, 1957 to Feb. 16, 1957 , that I last saw the deceased alive on Feb. 4, 1957 , and that death occurred at 12:57 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3066 Quind. St. Wash D.C. DATE SIGNED ACTUAL SIGNATURE E. Stuart Lyddane M.D. PHYSICIAN'S NAME (Type) E. STUART LYDDANE			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/19/57	22c. NAME OF CEMETERY OR CREMATORY NATIONAL MEM. PARK CEMETERY	22d. LOCATION (City, town, or county) (State) FALLS CHURCH, VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR 2/20/57	24b. REGISTRAR'S SIGNATURE William D. Dadd

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE IN DEATH		MAYLAND	
DATE OF DEATH		FEBRUARY 25 1957	
PLACE OF DEATH		BALTIMORE	
AGE		30	
SEX		F	
RACE		W	
EDUCATION		HIGHER	
OCCUPATION		Nurse	
MARRIAGE		MARRIED	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF DECEASED		[Signature]	
SIGNATURE OF WITNESS		[Signature]	
SIGNATURE OF PHYSICIAN		[Signature]	
SIGNATURE OF CLERK		[Signature]	
SIGNATURE OF JUDGE		[Signature]	
SIGNATURE OF SHERIFF		[Signature]	
SIGNATURE OF CORONER		[Signature]	
SIGNATURE OF DISTRICT ATTORNEY		[Signature]	
SIGNATURE OF COUNTY CLERK		[Signature]	
SIGNATURE OF TOWNSHIP CLERK		[Signature]	
SIGNATURE OF VILLAGE CLERK		[Signature]	
SIGNATURE OF CITY CLERK		[Signature]	
SIGNATURE OF STATE CLERK		[Signature]	
SIGNATURE OF NATIONAL CLERK		[Signature]	
SIGNATURE OF INTERNATIONAL CLERK		[Signature]	
SIGNATURE OF UNITED NATIONS CLERK		[Signature]	
SIGNATURE OF WORLD CLERK		[Signature]	
SIGNATURE OF GALAXY CLERK		[Signature]	
SIGNATURE OF UNIVERSE CLERK		[Signature]	
SIGNATURE OF COSMOS CLERK		[Signature]	
SIGNATURE OF INFINITY CLERK		[Signature]	
SIGNATURE OF ETERNITY CLERK		[Signature]	
SIGNATURE OF TIME CLERK		[Signature]	
SIGNATURE OF SPACE CLERK		[Signature]	
SIGNATURE OF MATTER CLERK		[Signature]	
SIGNATURE OF ENERGY CLERK		[Signature]	
SIGNATURE OF LIFE CLERK		[Signature]	
SIGNATURE OF DEATH CLERK		[Signature]	

BUREAU V. S.

FEB 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02017

2006

CERTIFICATE OF DEATH

Reg. Dist. No.

212

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson--Rural		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 Dickerson--Rural	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Guy Middle V Last Lewis		4. DATE OF DEATH Month Feb Day 4 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2-1898
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm owner & Grower of peaches		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph Hooker Lewis		14. MOTHER'S MAIDEN NAME Virginia Kolbaugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 1917-1918	
17. INFORMANT Guy V. Lewis, Jr. Dickerson Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct Posterior 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis with insufficiency DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 36 days 36 days 3 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 JANUARY, 19 57 to 4 February 19 57 , that I last saw the deceased alive on 4 February 19 57 , and that death occurred at 12:25 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) BARNESVILLE DATE SIGNED 5 Feb 57 ACTUAL SIGNATURE John M. Smith M.D. GORDON M. SMITH PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/7/57	
22c. NAME OF CEMETERY OR CREMATORY Mt Olivet		22d. LOCATION (City, town, or county) (State) Frederick Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton, Barnesville Md		24a. REC'D BY REGISTRAR DATE 2/7/57	
24b. REGISTRAR'S SIGNATURE Charles W. Elgin		24c. REGISTRAR'S SIGNATURE per 2/8	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

Place of Birth

Place of Death

Sex

Age

Color

Height

Weight

Married

Wife

Sept. 1-1955

SS

Person owned a license of motor vehicle

Maryland

Joseph Hooker Lewis

Virginia Kelpack

Yes

1917-1918

1919-1920

Rev. V. Lewis, Jr., Baltimore, Maryland

BUREAU V. 1

FEB 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO REGISTAR DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2007

CERTIFICATE OF DEATH

02018

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrett Park Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrett Park Kensington, Md x2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5009 Cushing Dr</u>		d. STREET ADDRESS <u>5009 Cushing Dr</u>	
3. NAME OF DECEASED (Type or print) <u>Victoria</u> First <u>Anna</u> Middle <u>Litak</u> Last		4. DATE OF DEATH <u>Feb. 12,</u> Month <u>12,</u> Day <u>19</u> Year <u>57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28 1892</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>14</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Woichik</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>062-24-7045</u>	
17. INFORMANT <u>Raymond Ksiazek</u> Address <u>5009 Cushing Dr</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion - Acute</u> <u>420.1</u> DUE TO <u>Arteriosclerosis - Hardened - Coronary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis - Hardened - Coronary</u> DUE TO (c) <u>Arteriosclerosis - Hardened - Coronary</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/19/57</u> , 19 <u>57</u> , to <u>2/12/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/12/57</u> , 19 <u>57</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel Allen</u> M.D. <u>Kensington</u>		ADDRESS (Street, city or town, state) <u>Kensington, Md</u> DATE SIGNED <u>2/12/57</u>	
PHYSICIAN'S NAME (Type) <u>SAMUEL ALLEN</u>		<u>KENSINGTON, MD.</u> <u>2-12-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-15-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Lackawanna County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u> ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>2-15-57</u> 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

REG. ONE IN

Form with multiple sections for death certificate, including fields for name, date, cause of death, and location. The text is mostly illegible due to blurriness.

BUREAU V. 3

FEB 18 1957

RECEIVED

Form with fields for signature, date, and other administrative details. The text is mostly illegible due to blurriness.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02019

2008

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY BG.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 1 Day		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16X22 Oxon Hill		
f. STREET ADDRESS 5921 Loch Court			g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Ah Middle (nmn) Last LOY			4. DATE OF DEATH Month February Day 25 Year 19 57		
5. SEX Male	6. COLOR OR RACE Chinese	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 August 1870		9. AGE (In years last birthday) 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)	11. BIRTHPLACE (State or foreign country) China		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I	17. INFORMANT Mrs. Norena R. Kai (Foster-Daughter) (Same As #2)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, multi-lobar DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 25 Feb. , 19 57 , to 25 Feb. , 19 57 , that I last saw the deceased alive on 25 Feb. , 19 57 , and that death occurred at 10:17 P.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE J. Dunn Jr		M.D. U.S. Naval Hospital, Bethesda, Md. 2-26-57			
PHYSICIAN'S NAME (Type) T.S. DUNN, JR, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1 March 57	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Va.		
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home			ADDRESS Washington, D.C.		24a. REC'D BY REGISTRAR DATE 2-25-57
			24b. REGISTRAR'S SIGNATURE Mary E. Carrelly		

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mostly illegible due to blurriness.

BUREAU V. S.

FEB 27 1957

RECEIVED

2009

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster 06-27-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 Asbury Methodist Home</u>				d. STREET ADDRESS <u>164 West Main St.</u>			
3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>MALEHORN</u> Last <u>MALEHORN</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 23, 1873</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>saleslady</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>dry goods store</u>		11. BIRTHPLACE (State or foreign country) <u>Westminster, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Andrew Jackson Malehorn</u>				14. MOTHER'S MAIDEN NAME <u>Ellen B. Koontz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>		17. INFORMANT Address <u>Methodist Home Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Central hemorrhage</u> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6-14</u> , 19 <u>56</u> , to <u>2-20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-20</u> , 19 <u>57</u> , and that death occurred at <u>9:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sarah E. Glover</u>				ADDRESS (Street, city or town, state) <u>4208 Anthony St Kensington Md.</u>			
DATE SIGNED <u>2-20-57</u>							
PHYSICIAN'S NAME (Type) <u>SARAH E. GLOVER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-22-57</u>		22c. NAME OF CEMETERY, OR CREMATORY <u>Westminster Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westminster Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed. Barton</u>				ADDRESS <u>Gaithersburg Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Feb-21-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Abigail G. Cooke</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

<p>NAME OF DECEASED <i>John E. Brown</i></p>		<p>DATE OF DEATH <i>Feb 23 1957</i></p>	
<p>AGE <i>68</i></p>		<p>SEX <i>Male</i></p>	
<p>DATE OF BIRTH <i>Nov 15 1888</i></p>		<p>PLACE OF BIRTH <i>St. Louis, Mo.</i></p>	
<p>EDUCATION <i>High School</i></p>		<p>OCCUPATION <i>Retired</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>IMMEDIATE CAUSE <i>Myocardial Infarction</i></p>	
<p>INTERVIEWED BY <i>Dr. J. H. Smith</i></p>		<p>DATE OF INTERVIEW <i>Feb 24 1957</i></p>	
<p>SIGNATURE OF DECEASED <i>John E. Brown</i></p>		<p>SIGNATURE OF WITNESS <i>Dr. J. H. Smith</i></p>	
<p>DATE OF SIGNATURE <i>Feb 23 1957</i></p>		<p>DATE OF SIGNATURE <i>Feb 24 1957</i></p>	

BUREAU V. S.

FEB 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02021

2010

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	c. LENGTH OF STAY IN 1b <u>18 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6131 Nevada Avenue</u>		d. STREET ADDRESS <u>1 6131 Nevada Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM HOWARD MARK</u>		4. DATE OF DEATH Month Day Year <u>FEB 16 19 57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 5, 1869</u>
9. AGE (In years lost birthday) yrs. <u>87</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pullman Conductor (Retired) Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13. FATHER'S NAME <u>William Franklin Marr</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Sweeney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>SISTER - Lulu Eno-Chevy Chase, Md.</u>		Address <u>6131 Nevada Ave.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA STOMACH</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERY DISEASE</u> DUE TO (c) <u>CHRONIC PULMONARY FIBROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 MOS</u> <u>10 YRS</u> <u>20 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>DEC 21, 1942</u> , to <u>FEB 16, 1957</u> , that I last saw the deceased alive on <u>FEB 15, 19 57</u> , and that death occurred at <u>3:30 A.M.</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Robert G. Taylor</u> M.D. <u>Washington Clinic</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT G. TAYLOR</u> <u>Washington 15, D.C.</u>			

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/18/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		24a. REC'D BY REGISTRAR <u>FEB 18 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>
ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>			

CERTIFICATE OF DEATH

Form 100-100

1. NAME OF DECEASED William Howard Myers		2. SEX M		3. AGE 45	
4. DATE OF DEATH Feb 15 1957		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. STREET ADDRESS 1017 Nevada Avenue		8. CITY Baltimore		9. STATE Maryland	
10. COUNTY Baltimore		11. ZIP CODE 21205		12. MARRIAGE Married	
13. OCCUPATION Salesman		14. CAUSE OF DEATH Myocardial Infarction		15. MANNER OF DEATH Natural	
16. SIGNATURE OF PHYSICIAN [Signature]		17. SIGNATURE OF DECEASED [Signature]		18. SIGNATURE OF WITNESS [Signature]	
19. SIGNATURE OF REGISTRAR [Signature]		20. SIGNATURE OF CLERK [Signature]		21. SIGNATURE OF JUDGE [Signature]	
22. SIGNATURE OF NOTARY [Signature]		23. SIGNATURE OF CHURCH [Signature]		24. SIGNATURE OF FUNERAL HOME [Signature]	
25. SIGNATURE OF BURIAL PLACE [Signature]		26. SIGNATURE OF CEMETERY [Signature]		27. SIGNATURE OF INTERMENT [Signature]	
28. SIGNATURE OF CREMATION [Signature]		29. SIGNATURE OF CEMETERY [Signature]		30. SIGNATURE OF INTERMENT [Signature]	
31. SIGNATURE OF CREMATION [Signature]		32. SIGNATURE OF CEMETERY [Signature]		33. SIGNATURE OF INTERMENT [Signature]	
34. SIGNATURE OF CREMATION [Signature]		35. SIGNATURE OF CEMETERY [Signature]		36. SIGNATURE OF INTERMENT [Signature]	
37. SIGNATURE OF CREMATION [Signature]		38. SIGNATURE OF CEMETERY [Signature]		39. SIGNATURE OF INTERMENT [Signature]	
40. SIGNATURE OF CREMATION [Signature]		41. SIGNATURE OF CEMETERY [Signature]		42. SIGNATURE OF INTERMENT [Signature]	
43. SIGNATURE OF CREMATION [Signature]		44. SIGNATURE OF CEMETERY [Signature]		45. SIGNATURE OF INTERMENT [Signature]	
46. SIGNATURE OF CREMATION [Signature]		47. SIGNATURE OF CEMETERY [Signature]		48. SIGNATURE OF INTERMENT [Signature]	
49. SIGNATURE OF CREMATION [Signature]		50. SIGNATURE OF CEMETERY [Signature]		51. SIGNATURE OF INTERMENT [Signature]	
52. SIGNATURE OF CREMATION [Signature]		53. SIGNATURE OF CEMETERY [Signature]		54. SIGNATURE OF INTERMENT [Signature]	
55. SIGNATURE OF CREMATION [Signature]		56. SIGNATURE OF CEMETERY [Signature]		57. SIGNATURE OF INTERMENT [Signature]	
58. SIGNATURE OF CREMATION [Signature]		59. SIGNATURE OF CEMETERY [Signature]		60. SIGNATURE OF INTERMENT [Signature]	
61. SIGNATURE OF CREMATION [Signature]		62. SIGNATURE OF CEMETERY [Signature]		63. SIGNATURE OF INTERMENT [Signature]	
64. SIGNATURE OF CREMATION [Signature]		65. SIGNATURE OF CEMETERY [Signature]		66. SIGNATURE OF INTERMENT [Signature]	
67. SIGNATURE OF CREMATION [Signature]		68. SIGNATURE OF CEMETERY [Signature]		69. SIGNATURE OF INTERMENT [Signature]	
70. SIGNATURE OF CREMATION [Signature]		71. SIGNATURE OF CEMETERY [Signature]		72. SIGNATURE OF INTERMENT [Signature]	
73. SIGNATURE OF CREMATION [Signature]		74. SIGNATURE OF CEMETERY [Signature]		75. SIGNATURE OF INTERMENT [Signature]	
76. SIGNATURE OF CREMATION [Signature]		77. SIGNATURE OF CEMETERY [Signature]		78. SIGNATURE OF INTERMENT [Signature]	
79. SIGNATURE OF CREMATION [Signature]		80. SIGNATURE OF CEMETERY [Signature]		81. SIGNATURE OF INTERMENT [Signature]	
82. SIGNATURE OF CREMATION [Signature]		83. SIGNATURE OF CEMETERY [Signature]		84. SIGNATURE OF INTERMENT [Signature]	
85. SIGNATURE OF CREMATION [Signature]		86. SIGNATURE OF CEMETERY [Signature]		87. SIGNATURE OF INTERMENT [Signature]	
88. SIGNATURE OF CREMATION [Signature]		89. SIGNATURE OF CEMETERY [Signature]		90. SIGNATURE OF INTERMENT [Signature]	
91. SIGNATURE OF CREMATION [Signature]		92. SIGNATURE OF CEMETERY [Signature]		93. SIGNATURE OF INTERMENT [Signature]	
94. SIGNATURE OF CREMATION [Signature]		95. SIGNATURE OF CEMETERY [Signature]		96. SIGNATURE OF INTERMENT [Signature]	
97. SIGNATURE OF CREMATION [Signature]		98. SIGNATURE OF CEMETERY [Signature]		99. SIGNATURE OF INTERMENT [Signature]	
100. SIGNATURE OF CREMATION [Signature]		101. SIGNATURE OF CEMETERY [Signature]		102. SIGNATURE OF INTERMENT [Signature]	

BUREAU V. 1

FEB 18 1957

RECEIVED

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

I TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02022

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		STATE MARYLAND		COUNTY MONTGOMERY			
CITY (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		LENGTH OF STAY (in this place) 1 week		CITY (If outside corporate limits, write RURAL and give nearest town) KENSINGTON			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Le DEAU NURSING HOME		STREET ADDRESS 10,613 CONCORD STREET					
3. NAME OF DECEASED (First) (Middle) (Last) AVONDALE PURDUM MATTHEWS				4. DATE OF DEATH (Month) (Day) (Year) FEB 2 1957			
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 9/14/76	9. AGE last birthday 80 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) CLARKSBURG, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES THOMAS PURDUM				14. MOTHER'S MAIDEN NAME HARRIET HOBBS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS Mr. William F. Matthews 10,613 Concord St., Kensington Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
296X IMMEDIATE CAUSE (A) HEART FAILURE, ACUTE				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) MYELOTHISIC ANEMIA				4 mo.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) THROMBOCYTOPENIA							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from NOV, 1956, to FEB 2, 1957, that I last saw the deceased alive on FEB 2, 1957, and that death occurred at 9:45 A.M., from the causes and on the date stated above.							
SIGNATURE Robert J. Philo deane, M.D.				ADDRESS (Street, city, town, state) M.D. 10609 Concord St. Kensington, Md		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 2/4/57		NAME OF CEMETERY OR CREMATORY CEDAR GROVE BAPTIST CHURCH CEMETERY		LOCATION (City, town, or county) (State) CEDAR GROVE, MARYLAND	
24. REC'D BY REGISTRAR DATE 2-6-57		REGISTRAR'S SIGNATURE Frances Potter		25. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.	

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

25 OCTOBER 1957

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE SIGNED AND DATED BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BOSTON, MASSACHUSETTS.

BUREAU V. 3

FEB 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2012 Item 12, Film G211, 3/8/57 bh
CERTIFICATE OF DEATH

02023
214

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Medgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>670 47X-3</u>		d. STREET ADDRESS <u>610 Princeton Pl. NW</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanatorium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fredrick</u> Middle <u>G.</u> Last <u>Meyer</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/22/79</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Purchaser</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Meyer</u>		14. MOTHER'S MAIDEN NAME <u>Frieda Wolfe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>834 East ave. Silver Spring Md.</u>	
17. INFORMANT <u>Mrs. Frank A. Gunther</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Dis.</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>o. 9.</u> Month <u>19</u> Day <u>19</u> Year <u>1957</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>54</u> , to <u>Feb 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 22</u> , 19 <u>57</u> , and that death occurred at <u>5:55 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>F. R. Ray, Md.</u> M.D.			
PHYSICIAN'S NAME (Type) <u>S. L. TABB, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/25/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Andrew's Church Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Hedgesville West Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. F. Schumacher & Son</u>		24a. REC'D BY REGISTRAR <u>2-28-57</u>	
ADDRESS <u>5732 Ha Line Wash D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

RECEIVED

2013
CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery Mont g.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN IB 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montg. Co. Gen.		d. STREET ADDRESS none	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Griffith Last Mobley		4. DATE OF DEATH Month Feb. Day 24 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/9/1867
9. AGE (In years last birthday) 89		IF UNDER 1 YEAR Months 10 Days 15	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME David Griffith		14. MOTHER'S MAIDEN NAME Anna S. Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hosp. Records		Address Olney, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 331X DUE TO Cerebral Vascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 2 days 11 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 8, 1957 , 19 Feb 24 , 19 57 , that I last saw the deceased alive on Feb 24 , 19 57 , and that death occurred at 10:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE F. J. Broschert M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Gaithersburg, Md. 2-24-57	
PHYSICIAN'S NAME (Type) F. J. Broschert			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/26/57	22c. NAME OF CEMETERY OR CREMATORY Rockville Union	22d. LOCATION (City, town, or county) (State) Rockville Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR 2-26-57		24b. REGISTRAR'S SIGNATURE Bertulus Lawbr	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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Background

Amesbury, N. H. 1897.

MAR 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22 FilmG211 2-25-57 et

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Wesley Carr MONTAGUE		4. DATE OF DEATH Month February Day 14 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 27 Jan. 1898
9. AGE (In years last birthday) 59 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Promoter	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Wesley Montague		14. MOTHER'S MAIDEN NAME Luola Flemming	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-I		16. SOCIAL SECURITY NO. 578 24 6269	
17. INFORMANT (Sister) Mrs. Ida M. Atkins		Address Richmond, Va. 411 N. Allen Ave.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 148X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) METASTATIC CARCINOMA DUE TO (c) SQUAMOUS CELL CARCINOMA OF PHARYNX		INTERVAL BETWEEN ONSET AND DEATH 2 MOS 2 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 Month, Day, Year p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 Nov. 19 56 to 14 Feb. 19 57 , that I last saw the deceased alive on 14 Feb. 19 57 , and that death occurred at 1:55 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 2-14-57			
ACTUAL SIGNATURE G. W. Taylor		PHYSICIAN'S NAME (Type) G. W. TAYLOR, CDR, MC, USN	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-19-57	
22c. NAME OF CEMETERY OR CREMATORY Jerusalem Church Cemetery		22d. LOCATION (City, town, or county) (State) King William Co., Va. Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers		24. REC'D BY REGISTRAR 2-14-57	
24a. REGISTRAR'S SIGNATURE W. W. Chambers		24b. REGISTRAR'S SIGNATURE W. W. Chambers	

1925

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hosp.</i>				d. STREET ADDRESS <i>805 New York Ave</i>			
3. NAME OF DECEASED (Type or print) <i>Juanita Celestia Moorhead</i>				4. DATE OF DEATH Month <i>2</i> Day <i>23</i> Year <i>1957</i>			
5. SEX <i>fe</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7-14-97</i>	
9. AGE (In years last birthday) <i>59</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <i>Ohio</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>William Robinson</i>				14. MOTHER'S MAIDEN NAME <i>Cora Naylor</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>None</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <i>Hospital Record + Husband</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal carcinoma</i> <i>151X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Primary carcinoma of stomach</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>2/15</i> , 1957, to <i>2/23</i> , 1957, that I last saw the deceased alive on <i>2/23</i> , 1957, and that death occurred at <i>1:37</i> P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <i>Eino Magri</i> M.D.				<i>8401 University Lane, Silver Spring, Maryland</i>			
PHYSICIAN'S NAME (Type) <i>EINO MAGRI</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>CREMATION</i>		<i>FEB 26, 1957</i>		<i>CEDARHILL CREMATORY</i>		<i>PAGE EXT. PR. GEO. CO. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. ...</i>				24. REC'D BY REGISTRAR <i>FEB 25 1957</i>			
ADDRESS <i>2510 ...</i>				25. REGISTRAR'S SIGNATURE <i>William Dodd</i>			

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CERTIFICATE OF DEATH

[Faint, mostly illegible text from the reverse side of the document is visible through the paper. Discernible words include "BUREAU V. S.", "FEB 27 1957", and "RECEIVED".]

BUREAU V. S.

FEB 27 1957

RECEIVED

2015

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>1 month</u>		d. STREET ADDRESS <u>19605 Dallas Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10005 Tenbrook Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Virginia Boxwell Moulden</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 10 - 1896</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Worcester, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edmond Glaze</u>		14. MOTHER'S MAIDEN NAME <u>Emma Boxwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Percy Nelson Moulden</u>		Address <u>9605 Dallas Ave Silver Spring, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gen Arteriosclerosis & Hypertension</u> DUE TO (c) <u>Cerebral Hem. - left Hemiplegia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs.</u> <u>Jan 1943</u> <u>DEC 14 1956</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/9/1943</u> to <u>2/12/1957</u> , that I last saw the deceased alive on <u>2/12/1957</u> , and that death occurred at <u>11:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard T. Morse</u>		M.D. <u>2030 Carroll Ave</u>	
PHYSICIAN'S NAME (Type) <u>Howard T. Morse</u>		Address <u>Takoma Park, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2/13/57</u>	<u>Arlington Mtl</u>	<u>Arlington, Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u>		ADDRESS <u>Silver Spring, Md</u>	
24a. REC'D BY REGISTRAR <u>1/16/57</u>		24b. REGISTRAR'S SIGNATURE <u>Frances J. Teller</u>	

MEDICAL CERTIFICATION

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FEB 19 1957

RECEIVED

2016 CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Marroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 18 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				f. STREET ADDRESS South Main Street			
3. NAME OF DECEASED (Type or print) First Middle Last Clifton Asbury Mullinix				4. DATE OF DEATH Month Day Year February 14 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/21/78 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner Lumbar Company		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Mullinix				14. MOTHER'S MAIDEN NAME Rachel Poole			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 217-12-2003		17. INFORMANT Address Hospital Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarct DUE TO (b) acute coronary thrombosis DUE TO (c) coronary atherosclerosis CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 3 week 11 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) acute pulmonary infarct				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 27, 19 57 , to Feb 14, 19 57 , that I last saw the deceased alive on Feb 14, 19 57 , and that death occurred at 11:30 A.M. , from the causes and on the date stated above.				DATE SIGNED 2/14/57			
ACTUAL SIGNATURE G. F. Meadors M.D. Boyer				ADDRESS (Street, city or town, state) Damascus, Md.			
PHYSICIAN'S NAME (Type) G. F. Meadors, M. D.				22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			
22b. DATE THEREOF 2-16-1957				22c. NAME OF CEMETERY OR CREMATORY Montgomery Chapel		22d. LOCATION (City, town, or county) (State) Montgomery Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, ADDRESS Winfield, Md.				24a. REC'D BY REGISTRAR HEB 18 1957		24b. REGISTRAR'S SIGNATURE Gertrude Lawley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

✓ 2014

Source: *Author's calculations*.

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FEB 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG211 2-28-57 et

2017

CERTIFICATE OF DEATH

02029

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE C. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 14 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 3387 Stephenson Pl. NW			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Sophie First Josephine Middle Nolda Last				4. DATE OF DEATH February Month 18 Day 57 Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6, 1875	
9. AGE (In years last birthday) yrs. 81		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Austria-Hungary				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Mathias Dworack				14. MOTHER'S MAIDEN NAME Anna Janecak			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT son - same				Address Henry Nolda			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Confluent Bronchopneumonia ^{st upper lobe} 904.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Concussion DUE TO 14 days (c) Fall at home DUE TO 14 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Advanced Arteriosclerosis							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell over bathtub.			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 3 2/4 1957				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home				20f. (City or town) (County) (State) Washington, D.C.			
21. I certify that I attended the deceased from 7/1 , 19 55 , to 2/18 , 19 57 , that I last saw the deceased alive on 2/18 , 19 57 , and that death occurred at 8:57 A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED 9300 Ewing Dr. Bethesda, M.D. 2/18/57							
ACTUAL SIGNATURE Seymour Greenbaum M.D.							
PHYSICIAN'S NAME (Type) SEYMOUR GREENBAUM, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2/21/57			
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery				22d. LOCATION (City, town, or county) (State) Washington, D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington, D.C.				24a. REC'D BY REGISTRAR 2-20-57			
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

FEB 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2018 CERTIFICATE OF DEATH

0203014

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Silver Spring</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HERBERT</u> Middle <u>ALLEN</u> Last <u>OSBOURN</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>23RD</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 9, 1893</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>OATLAND, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ALEXANDER LINK OSBOURN</u>				14. MOTHER'S MAIDEN NAME <u>FRANCES VIRGINIA SMITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>DR. RAYMOND A. OSBOURN</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY HEART DISEASE</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 MONTHS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 3, 1953</u> , to <u>February 23, 1957</u> , that I last saw the deceased alive on <u>FEB 23, 1957</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Michael J. McInerney</u> M.D.				ADDRESS (Street, city or town, state) <u>1150 - CONN AVE NW</u>			
PHYSICIAN'S NAME (Type) <u>MICHAEL J. MCINERNEY</u>				DATE SIGNED <u>FEB 25 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2-25-57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WASH. DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Haulon</u> ADDRESS <u>3831- 20th NW WASH. D.C.</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>FEB 25 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Patter...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02031

2019

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Henry			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 31 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ 83X-3 Spencer				d. STREET ADDRESS Route # 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center National Institutes of Health, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sanders Middle Andrew Last Palmer			4. DATE OF DEATH Month February Day 28 Year 19 57				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 September 1888		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Self-employed farming		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William P. Palmer				14. MOTHER'S MAIDEN NAME Elizabeth Lawson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Record, Clinical Center National Institutes of Health, Bethesda 14, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA 205X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) MYCOSIS FUNGOIDES DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 21 days 21 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cystitis, pyelonephritis, emphysema							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 28, 19 57 , to February 28, 19 57 , that I last saw the deceased alive on February 28, 19 57 , and that death occurred at 4:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Samuel Charache M.D. The Clinical Center 3/1/57 National Institutes of Health Bethesda 14, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial-transit		3/2/1957		Stuart		Stuart Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey,				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 3-2-57	
				24b. REGISTRAR'S SIGNATURE Beenie M. Thompson			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02032

2020

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.		c. LENGTH OF STAY IN 1b 47 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle Tibbs Last Phillips		4. DATE OF DEATH Month February Day 19 Year 19 57	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 28, 1906
9. AGE (In years lost birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frank Tibbs		14. MOTHER'S MAIDEN NAME Unascertainable	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) myocardial irritability (c) Chronic pyelonephritis Hypertension		INTERVAL BETWEEN ONSET AND DEATH minutes months years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary congestion, edema and pleural effusion		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING, OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. NONE 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 3, 1957 , to February 19, 1957 , that I last saw the deceased alive on February 19, 1957 , and that death occurred at 9:25 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE William J. Pieper M.D.		ADDRESS (Street, city or town, state) The Clinical Center	
PHYSICIAN'S NAME (Type) William J. Pieper, M. D.		DATE SIGNED 2-20/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/25/57	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or County) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE R. N. Horton Co		ADDRESS 1322 U. S. St. N.W.	
24a. REC'D BY REGISTRAR FEB 25 1957		24b. REGISTRAR'S SIGNATURE Bennie Thompson	

CERTIFICATE OF DEATH

INVEST AND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

6 2 3 1 2

BUREAU V. S.

FEB 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02033
 Reg. Dist. No. **223**

1926

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>montg</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lakon Park</i>			c. LENGTH OF STAY IN 1b <i>4 wks</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x1 Silver Spring</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash Sen. & Hosp</i>				d. STREET ADDRESS <i>1 R.F.D. # 2</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Shawn</i> Middle <i>Ella</i> Last <i>Pickens</i>				4. DATE OF DEATH Month <i>2</i> Day <i>8</i> Year <i>1957</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>w</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-21-48</i>		9. AGE (In years last birthday) <i>9</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>DC</i>		12. CITIZEN OF WHAT COUNTRY? <i>USC</i>	
13. FATHER'S NAME <i>Hayward F Pickens</i>				14. MOTHER'S MAIDEN NAME <i>Ethel Allen</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hosp records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho pneumonia & pulmonary edema</i> <i>916.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>3rd degree burns (60% of body)</i> DUE TO (c) <i>4 wks</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Clothes caught on fire from trash fire at home</i>					
20c. TIME OF INJURY Month, Day, Year Hour <i>12:45</i> p.m. <i>1-12</i> 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Silver Spring Montg md</i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>				22b. DATE THEREOF <i>2/12/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>FT. LINCOLN CEMETERY</i>	
22d. LOCATION (City, town, or county) (State) <i>PRINCE GEORGE COUNTY, MD.</i>							
23. FUNERAL DIRECTOR'S SIGNATURE <i>Werner & Timofsky</i>				ADDRESS <i>8434 Ave S.S. no</i>		24. REC'D BY REGISTRAR 25. REGISTRAR'S SIGNATURE <i>FEB 12 1957</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2021 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda x 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4612 Montgomery Avenue				d. STREET ADDRESS 4612 Montgomery Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Arthur C POOLE				4. DATE OF DEATH Month Day Year February 18 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/12/1880	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 11 6		IF UNDER 24 HRS. 11 6			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. D.C. Fire Dept.				10b. KIND OF BUSINESS OR INDUSTRY Fireman		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Lorenza P. Poole				14. MOTHER'S MAIDEN NAME Sally Sarah M. Devine			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 577-01-8908			
17. INFORMANT Ida C. Poole, 4612 Montg. Ave. Beth. Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Left Ventricular Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb 16, 1957 , to Feb 18, 1957 , that I last saw the deceased alive on Feb 18, 1957 , and that death occurred at 11:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Paul D. Cantor M.D. 4709 Montgomery Lane, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF 2/18/57		22c. NAME OF CEMETERY OR CREMATORY Rockville Union		22d. LOCATION (City, town, or county) (State) Rockville Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE 2-20-57		24b. REGISTRAR'S SIGNATURE Beattie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MONTGOMERY		MONTGOMERY	
FEBRUARY 25 1957		FEBRUARY 25 1957	
4013 MONTGOMERY AVENUE		4013 MONTGOMERY AVENUE	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
FEMALE		FEMALE	
WHITE		WHITE	
MARRIED		MARRIED	
BORN 1918		BORN 1918	
DIED 1957		DIED 1957	
CAUSE OF DEATH		CAUSE OF DEATH	
DISEASE		DISEASE	
SYMPTOMS		SYMPTOMS	
TREATMENT		TREATMENT	
BURIAL		BURIAL	
INTERVIEW		INTERVIEW	
SIGNATURE		SIGNATURE	
DATE		DATE	
PLACE		PLACE	
OFFICE		OFFICE	
COUNTY		COUNTY	
STATE		STATE	
FEDERAL		FEDERAL	
LOCAL		LOCAL	
NATIONAL		NATIONAL	
INTERNATIONAL		INTERNATIONAL	
OTHER		OTHER	
REMARKS		REMARKS	
FAMILY HISTORY		FAMILY HISTORY	
SOCIAL HISTORY		SOCIAL HISTORY	
OCCUPATIONAL HISTORY		OCCUPATIONAL HISTORY	
EDUCATIONAL HISTORY		EDUCATIONAL HISTORY	
MILITARY HISTORY		MILITARY HISTORY	
RELIGIOUS HISTORY		RELIGIOUS HISTORY	
LEGAL HISTORY		LEGAL HISTORY	
MEDICAL HISTORY		MEDICAL HISTORY	
SURGICAL HISTORY		SURGICAL HISTORY	
DENTAL HISTORY		DENTAL HISTORY	
PSYCHIATRIC HISTORY		PSYCHIATRIC HISTORY	
OBSTETRIC HISTORY		OBSTETRIC HISTORY	
GYNACOLOGY HISTORY		GYNACOLOGY HISTORY	
UROLOGY HISTORY		UROLOGY HISTORY	
PEDIATRICS HISTORY		PEDIATRICS HISTORY	
GERIATRICS HISTORY		GERIATRICS HISTORY	
NEUROLOGY HISTORY		NEUROLOGY HISTORY	
OPHTHALMOLOGY HISTORY		OPHTHALMOLOGY HISTORY	
ENT HISTORY		ENT HISTORY	
DERMATOLOGY HISTORY		DERMATOLOGY HISTORY	
RHEUMATOLOGY HISTORY		RHEUMATOLOGY HISTORY	
IMMUNOLOGY HISTORY		IMMUNOLOGY HISTORY	
ONCOLOGY HISTORY		ONCOLOGY HISTORY	
ENDOCRINOLOGY HISTORY		ENDOCRINOLOGY HISTORY	
METABOLISM HISTORY		METABOLISM HISTORY	
NUTRITION HISTORY		NUTRITION HISTORY	
EXERCISE HISTORY		EXERCISE HISTORY	
SLEEP HISTORY		SLEEP HISTORY	
DIET HISTORY		DIET HISTORY	
TOBACCO HISTORY		TOBACCO HISTORY	
ALCOHOL HISTORY		ALCOHOL HISTORY	
DRUGS HISTORY		DRUGS HISTORY	
MISCELLANEOUS HISTORY		MISCELLANEOUS HISTORY	

BUREAU V. S.
FEB 25 1957
RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2022

CERTIFICATE OF DEATH

02035

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>19529 Erving Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Max</u> Middle <u>Charles</u> Last <u>Rabourn</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 12 1867</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Rocaft</u>		14. MOTHER'S MAIDEN NAME <u>Leha Mcnea</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Helen Clifford</u>		Address <u>9529 Erving Dr Bethesda Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> DUE TO <u>174X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastatic cancer, widespread</u> DUE TO (c) <u>Sarcoma, uterus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1+ yrs</u> <u>10+ yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260 diabetes, arteriosclerotic heart disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>57</u> , to <u>Feb 10</u> 19 <u>57</u> , that I last saw the deceased alive on <u>2/10</u> , 19 <u>57</u> , and that death occurred at <u>3:35 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles J. Savarese</u> M.D.		ADDRESS (Street, city or town, state) <u>4861 Battery Lane</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVARESE, J. Bethesda, Md</u>		DATE SIGNED <u>2/11/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/14/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Wash DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. A. Huntman & Son</u>		24a. REC'D BY REGISTRAR <u>2-14-57</u>	
ADDRESS <u>5732 Ka Ave NW</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

[Faint, mostly illegible handwritten text on a death certificate form. Visible fragments include:]

NAME: *John J. ...*
 SEX: *Male*
 AGE: *65*
 DATE OF DEATH: *Feb 18 1957*
 PLACE OF DEATH: *Home*
 CAUSE OF DEATH: *Heart Disease*
 SIGNATURE: *[Illegible]*

BUREAU V. S.

FEB 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1c Film 0211 2-20-57 et

2023

CERTIFICATE OF DEATH

02036

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Daniel Abner Ramage			4. DATE OF DEATH Month Day Year February 14, 1957				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23, 1886	9. AGE (In years lost birthday) yrs. 70	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Engineering		11. BIRTHPLACE (State or foreign country) Pennsylvania			
13. FATHER'S NAME George Ramage			14. MOTHER'S MAIDEN NAME Sarah Heatherly				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 194-01-2718		17. INFORMANT The Medical Record, The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diverticulitis and peritonitis 572.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Abscess of prostate DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, Heart disease, Cancer of the liver, Rheumatoid arthritis 420.1					INTERVAL BETWEEN ONSET AND DEATH 3		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
		20f. (City or town)		(County) (State)			
21. I certify that I attended the deceased from September 22, 1954 to February 14, 1957 , that I last saw the deceased alive on February 14, 1957 , and that death occurred at 11:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE James R. Stabenau		M.D. The Clinical Center		ADDRESS (Street, city or town, state) National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) James R. Stabenau, M. D.		DATE SIGNED 2/19/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/18/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.			
				22d. LOCATION (City, town, or county) (State) Brooklyn, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes 130 E. Fort Ave.			24a. REC'D BY REGISTRAR Feb 19 1957				
			24b. REGISTRAR'S SIGNATURE Bessie Thompson				

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		NATURAL CAUSE	
AGE		SEX	
RACE		OCCUPATION	
EDUCATION		MARRIAGE	
RELIGION		PREVIOUS ILLNESS	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES	
DATE		PLACE	

BUREAU V. S.

FEB 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2024

CERTIFICATE OF DEATH

02037

216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 98 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1033 Quebec Terrace, Apt. 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John		Middle Walter		Last Robertson		4. DATE OF DEATH Month February , Day 5 , Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 10, 1907		9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographer		10b. KIND OF BUSINESS OR INDUSTRY Photography		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Robertson				14. MOTHER'S MAIDEN NAME Georgia Knott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-03-2620		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple myeloma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 30, 1957 to February 5, 1957 , that I last saw the deceased alive on February 5, 1957 , and that death occurred at 9:35 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James R. Stabenau		M.D. James R. Stabenau, M. D.		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 2/5/57	
PHYSICIAN'S NAME (Type) James R. Stabenau, M. D.		ADDRESS National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-8-57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee's Sons Co.				ADDRESS Washington,		24a. REC'D BY REGISTRAR FEB 7 1957	
				24b. REGISTRAR'S SIGNATURE Bessie Thompson			

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN P. ROBERTSON		AGE 37 YEARS		SEX MALE		RACE WHITE		DATE OF BIRTH JAN 15 1920		PLACE OF BIRTH BALTIMORE, MARYLAND	
FATHER'S NAME JOHN P. ROBERTSON		MOTHER'S NAME MARY E. ROBERTSON		FATHER'S OCCUPATION FARMER		MOTHER'S OCCUPATION HOUSEWIFE		FATHER'S BIRTH JAN 15 1883		MOTHER'S BIRTH JAN 15 1883	
DECEASED'S OCCUPATION FARMER		CAUSE OF DEATH HEART DISEASE		PERMANENT RESIDENCE BALTIMORE, MARYLAND		TEMPORARY RESIDENCE BALTIMORE, MARYLAND		DATE OF DEATH FEB 2 1957		PLACE OF DEATH BALTIMORE, MARYLAND	
DECEASED'S ADDRESS 1234 BALTIMORE AVE BALTIMORE, MARYLAND		DECEASED'S PHONE 1234		DECEASED'S SOCIAL SECURITY NO. 1234 56789		DECEASED'S MARITAL STATUS MARRIED		DECEASED'S RELIGION METHODIST		DECEASED'S EDUCATION HIGH SCHOOL	
DECEASED'S SIGNATURE JOHN P. ROBERTSON		DECEASED'S ADDRESS 1234 BALTIMORE AVE BALTIMORE, MARYLAND		DECEASED'S PHONE 1234		DECEASED'S SOCIAL SECURITY NO. 1234 56789		DECEASED'S MARITAL STATUS MARRIED		DECEASED'S RELIGION METHODIST	
DECEASED'S SIGNATURE JOHN P. ROBERTSON		DECEASED'S ADDRESS 1234 BALTIMORE AVE BALTIMORE, MARYLAND		DECEASED'S PHONE 1234		DECEASED'S SOCIAL SECURITY NO. 1234 56789		DECEASED'S MARITAL STATUS MARRIED		DECEASED'S RELIGION METHODIST	

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FEB 7 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2025 CERTIFICATE OF DEATH

Reg. Dist. No. 020286

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Florida</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14, Maryland</u>		c. LENGTH OF STAY IN 1b <u>143 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Orlando 48x-3</u>	
3. NAME OF DECEASED (Type or print) First <u>Sidney</u> Middle <u>Benard</u> Last <u>Schaeffer</u>		4. DATE OF DEATH Month <u>February</u> Day <u>10</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 15, 1939</u>
9. AGE (In years lost birthday) <u>17</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Earl Schaeffer</u>		14. MOTHER'S MAIDEN NAME <u>Mary McCraig</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Not available</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic glomerulonephritis</u> <u>592x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. 11.</u> Month <u>19</u> Day <u> </u> Year <u> </u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>September 20, 19 56</u> , to <u>February 10, 19 57</u> , that I last saw the deceased alive on <u>February 10, 19 57</u> , and that death occurred at <u>1:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas F. Dolan, Jr.</u>		M.D. <u>The Clinical Center</u> ADDRESS (Street, city or town, state) <u>National Institutes of Health</u> DATE SIGNED <u>2-10-57</u>	
PHYSICIAN'S NAME (Type) <u>Thomas F. Dolan, Jr., M. D.</u>		<u>Bethesda 14, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial-Transit</u>	<u>2/10/57</u>	<u>Woodlawn Memorial Park</u>	<u>Orlando, Florida</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>2-12-57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

INDICATE OF DEATH

INDICATE OF DEATH

BUREAU V. S.

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INSTRUCTIONS

1. **ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

2027

02040

214

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>AA.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>		LENGTH OF STAY (in this place) <u>Since 7/7-57</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Deale</u>		TOWN <u>02X02</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Le Beau Gardens</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>SOPHIE SCHWARTZ</u>				4. DATE OF DEATH (Month) <u>July</u> (Day) <u>14</u> (Year) <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 9-1868</u>	9. AGE last birthday <u>88</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>4</u>		IF UNDER 24 HRS. Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Deale, Prince George's County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Abraham Wurman</u>				14. MOTHER'S MAIDEN NAME <u>Pauline Brumavick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mr. Max Schwartz, Deale, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Dissecting Aneurysm Aorta</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic Heart Disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 14, 1955</u> , to <u>Feb 14, 1957</u> , that I last saw the deceased alive on <u>Feb 14, 1957</u> , and that death occurred at <u>9:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Robert J. Philadorean, M.D.</u>		ADDRESS (Street, city, town, state) <u>10609 Concord St., Kensington, Md.</u>		DATE SIGNED <u>15 Feb 57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2/17/57</u>		NAME OF CEMETERY OR CREMATORY <u>Nat'l. Cap. Hebrew Cem. Deale, Md.</u>		LOCATION (City, town, or county)	
24. REC'D BY REGISTRAR <u>Frances Oller</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>		ADDRESS <u>4217-9th St. N.W.</u>	

INSTRUCTIONS

These instructions are intended to guide the user in the use of the **UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE** **FORM NO. 101-1** **CERTIFICATE OF DEATH**. The instructions are divided into two parts: **Part I. Instructions to the User** and **Part II. Instructions to the Registrar**. The instructions are intended to be used by the user in the use of the form. The instructions are intended to be used by the user in the use of the form.

CERTIFICATE OF DEATH

U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

FORM NO. 101-1

INSTRUCTIONS TO THE USER

INSTRUCTIONS TO THE REGISTRAR

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

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SEX

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DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

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CAUSE OF DEATH

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EDUCATION

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DATE OF BIRTH

PLACE OF BIRTH

BUREAU V. S.

FEB 25 1957

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CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 8 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 83x-3 Alexandria			
d. STREET ADDRESS 1519 Huntington Ave.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Roy Last SHIBLEY				4. DATE OF DEATH Month February Day 12 Year 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 Sept. 1886		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner & Policeman			10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy & Gov't		11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME William Shibley				14. MOTHER'S MAIDEN NAME Florence Underwood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I		17. INFORMANT (Daughter) Mrs. Jean M. Shibley, 5003 Tuckerman		Address Riverdale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Cecum 153x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6-12 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 11 p. m. Month, Day, Year 19 57				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. Naval Hospital, Bethesda, Md.	
20f. (City or town) Bethesda, Md.				20g. (County) Montgomery		20h. (State) Md.	
21. I certify that I attended the deceased from 4 Feb. , 19 57 , to 12 Feb. , 19 57 , that I last saw the deceased alive on 12 Feb. , 19 57 , and that death occurred at 12:00 Midnight , from the causes and on the date stated above.							
ACTUAL SIGNATURE Larry J. Hines				M.D. U.S. Naval Hospital, Bethesda, Md. 2-13-57			
PHYSICIAN'S NAME (Type) Larry J. Hines, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-18-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Hysong Funeral Home, 1300 N. St., N.W. Wash. D.C.				24a. REC'D BY REGISTRAR DATE 2-13-57		24b. REGISTRAR'S SIGNATURE Harry E. Parrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John A. Thompson		Male		45	
Date of Death		Place of Death		Cause of Death	
Sept. 1, 1957		Home		Heart Disease	
Time of Death		Manner of Death		Occupation	
10:00 AM		Natural		Teacher	
Residence		U.S. Birth		U.S. Death	
1234 Main St., Baltimore, Md.		Yes		Yes	
Physician		Burial		Funeral Home	
Dr. J. H. Smith		Yes		St. John's	
Burial Place		Cremation		Remarks	
St. John's Cemetery		No			
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date		Time		Place	
Sept. 1, 1957		10:00 AM		Baltimore, Md.	

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1957

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may be retained by the hospital or attending physician. TO REGISTAR DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02039

2028

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>				d. STREET ADDRESS <u>11602 - ORchaugh S.S. Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Baby Boy</u> First Middle Last <u>Smallwood</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 4, 1957</u>	
9. AGE (In years last birthday) yrs. <u>3</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Mont. Co. Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Smallwood, ELMER E.</u>				14. MOTHER'S MAIDEN NAME <u>CARTER, JEAN - (nee Kussner)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Father</u> Address <u>Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Secondary causes (none)</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12⁵ - 5³⁰ pm</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12 noon</u> , 19 <u>57</u> , to <u>3 pm</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/4/57</u> , 19 <u>57</u> , and that death occurred at <u>3:06</u> M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Paul D. Cantor</u> M.D.				ADDRESS <u>4709 Montg. Lane, Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Paul D. Cantor</u>				ADDRESS <u>4709 Montgomery Lane, Beth.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2/26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Pr. Geo. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE <u>2-26-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

2074283XVO

BUREAU V. S.

EB 28 1957

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1 INSTRUCTIONS TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

1 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

2029 CERTIFICATE OF DEATH

02042

Reg. Dist. No. 214

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Silver Spring</u>	<u>5 yrs</u>	TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1902 Rockwood Rd.</u>		STREET ADDRESS (If rural give location)	<u>1902 Rockwood Rd.</u>
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>Susan Conant Snow</u>		<u>FEB 22 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug 1, 1868</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Elizabeth, N.C.</u>
13. FATHER'S NAME <u>Thomas Conant</u>		14. MOTHER'S MAIDEN NAME <u>Martha Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS <u>M. Robt. Snow Silver Spring</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH -		INTERVAL BETWEEN ONSET AND DEATH	
492x IMMEDIATE CAUSE (A) <u>Hypostatic Pneumonia</u>		<u>4 days</u>	
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerotic Heart Disease</u>			
19a. DATE OF OPERATION <u>420.0</u>	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept 7</u> , 19 <u>52</u> , to <u>Feb 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 21</u> , 19 <u>57</u> , and that death occurred at <u>4:45</u> M, from the causes and on the date stated above.			
SIGNATURE <u>James B. Banchard</u>		DATE SIGNED <u>2/22/57</u>	
ADDRESS (Street, city, town, state) <u>324 N Col. Blvd. S.D. Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>cremation</u>	DATE THEREOF <u>2/25/57</u>	NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>	LOCATION (City, town, or county) <u>Princes Georges County, Md.</u>
24. REC'D BY REGISTRAR <u>FEB 25 1957</u>	REGISTRAR'S SIGNATURE <u>James Potter</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>Wash. DC</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. DATE OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEXT OF KIN

17. SIGNATURE OF BURIAL OFFICIAL

18. SIGNATURE OF CHURCH OFFICIAL

19. SIGNATURE OF FUNERAL HOME

20. SIGNATURE OF CEMETERY

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF INTERVIEWER

24. SIGNATURE OF INTERVIEWER

25. SIGNATURE OF INTERVIEWER

26. SIGNATURE OF INTERVIEWER

27. SIGNATURE OF INTERVIEWER

28. SIGNATURE OF INTERVIEWER

29. SIGNATURE OF INTERVIEWER

30. SIGNATURE OF INTERVIEWER

31. SIGNATURE OF INTERVIEWER

32. SIGNATURE OF INTERVIEWER

33. SIGNATURE OF INTERVIEWER

34. SIGNATURE OF INTERVIEWER

RECEIVED

BUREAU V. S.

FEB 25 1957

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2030 CERTIFICATE OF DEATH

02043

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 2-years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9303 Parkhill Terrace				d. STREET ADDRESS 9303 Parkhill Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Fannie Archibald White Somerville				4. DATE OF DEATH Feb. 17 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1876		9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Archibald White				14. MOTHER'S MAIDEN NAME Mary E. Knowles			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Ida M. White		Address 9303 Parkhill Terrace Bethesda Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Carbosis of Liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 15, 1948 to Feb 17, 1957 , that I last saw the deceased alive on Feb 16, 1957 , and that death occurred at 2:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur H. Lewis				ADDRESS (Street, city or town, state) 1714 Rhode Island Ave N.W. Washington 6 DC			
PHYSICIAN'S NAME (Type) ARTHUR H. LEWIS				DATE SIGNED 2-17-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/19/57		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				ADDRESS 2901 14th St. N.W. Washington 9, D.C.		24a. REC'D BY REGISTRAR FEB 19 1957	
				24b. REGISTRAR'S SIGNATURE Bessie Thompson			

BUREAU V. S.

2031 CERTIFICATE OF DEATH

Reg. Dist. No. 2 17

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. Olney			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 16152 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sharon Nursing Home				d. STREET ADDRESS Riggs Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mary Middle Smith Last Sprowls				4. DATE OF DEATH Month Feb. Day 24, Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/27/1887		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington Co., Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Arthur Smith				14. MOTHER'S MAIDEN NAME Mary Paling			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. --		17. INFORMANT Address Nursing Home Records—R.F.D., Olney, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage Lower D.I. Tract 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Inoperable ca of sigmoid colon DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) _____							INTERVAL BETWEEN ONSET AND DEATH 5 days 2 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from 10 May 1952 to 23 Feb 1957 , that I last saw the deceased alive on 22 Feb 1957 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE John B. Ziegler M.D. Olney Md 24 Feb 57 PHYSICIAN'S NAME (Type) JOHN B. ZIEGLER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/57		22c. NAME OF CEMETERY OR CREMATORY Geo. Washington Memorial Prince Georges Co., Md.		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				23a. ADDRESS 2901 14th St., N.W.		23b. REC'D BY REGISTRAR FEB 27 1957	
24b. REGISTRAR'S SIGNATURE Gertude Lawless							

BUREAU V. S.

FEB 27 1957

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2032 CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 KENSINGTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS - SANITARIUM				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Jenora MASON Stone				4. DATE OF DEATH Month Day Year FEB 14, Thursday 1957			
5. SEX F	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 13 1876		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jenoras Fleming				14. MOTHER'S MAIDEN NAME Clorinda Cheney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Evelyn B. Richardson, Address Warren Green Hotel Warrenton, Virginia			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Senility						INTERVAL BETWEEN ONSET AND DEATH 1 month yr yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from July , 19 50 , to Feb 13 , 19 57 , that I last saw the deceased alive on Feb 14 , 19 57 , and that death occurred at 4:50 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Samuel Allen				ADDRESS (Street, city or town, state) DATE SIGNED 10,407 Fawcett St., Kensington, Md. 2/14/57			
PHYSICIAN'S NAME (Type) SAMUEL ALLEN							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/16/57		22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Abner E. Humphrey ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR DATE 2/16/57		24b. REGISTRAR'S SIGNATURE Frances Allen	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

FEB 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02046

2033 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt #1, Rockville x Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Florence Katherine Surber</u>		4. DATE OF DEATH Month Day Year <u>Feb 26 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 13 1913</u>
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>United States</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Address</u>	
17. INFORMANT <u>Alfred Surber</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute disseminated lupus erythematosus</u> <u>456X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Terminal pulmonary edema</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>2-15</u> , 19 <u>57</u> , to <u>2-25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-25</u> , 19 <u>57</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.	
21. ADDRESS (Street, city or town, state) <u>104 Cherry Chase Dr.</u>		21. DATE SIGNED <u>2/26/57</u>	
ACTUAL SIGNATURE <u>George A. Gray, Jr.</u> M.D.		PHYSICIAN'S NAME (Type) <u>George A. Gray, Jr.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/28/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE - 27-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF BIRTH <i>Jan 15 1912</i>		PLACE OF BIRTH <i>St. Louis, Mo.</i>	
MARRIED <i>Yes</i>		SINGLE <i>No</i>		WIDOWED <i>No</i>		DIVORCED <i>No</i>		MILITARY SERVICE <i>No</i>		OCCUPATION <i>Teacher</i>	
EDUCATION <i>High School</i>		RELIGION <i>Methodist</i>		MANNER OF DEATH <i>Natural</i>		CAUSE OF DEATH <i>Heart Disease</i>		IMMEDIATE CAUSE <i>Myocardial Infarction</i>		UNDERLYING CAUSE <i>Coronary Artery Disease</i>	
DATE OF DEATH <i>Mar 1 1957</i>		PLACE OF DEATH <i>Home</i>		TIME OF DEATH <i>10:00 AM</i>		SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESS <i>Dr. J. H. Smith</i>	
DATE OF REPORT <i>Mar 1 1957</i>		REPORTED BY <i>Dr. J. H. Smith</i>		REPORTED TO <i>Dr. J. H. Smith</i>		REPORTED BY <i>Dr. J. H. Smith</i>		REPORTED TO <i>Dr. J. H. Smith</i>		REPORTED BY <i>Dr. J. H. Smith</i>	

BUREAU V. 3

MAR 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2034 CERTIFICATE OF DEATH

Reg. Dist. No. 216

02047

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>XXXX D.C.</u> b. COUNTY <u>Washington</u> <u>47X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILLARD</u> Middle <u>B.</u> Last <u>SWINGLE</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>20</u> Year <u>1957</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 15, 1885</u>		9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Gov't.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auditor</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert Duncan Swingle</u>				14. MOTHER'S MAIDEN NAME <u>Emma Johnston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Marion A. Clark, 3917 Military Rd., N.W., D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exfoliating dermatitis</u> <u>705.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u> <u>Coronary heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 19</u> , 19 <u>57</u> , to <u>Feb 20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 20</u> , 19 <u>57</u> , and that death occurred at <u>9:30 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr Joseph Kenrick</u>		M.D.		ADDRESS (Street, city or town, state) <u>6450 Wisconsin Ave, Bethesda 20/2/1957</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Dr JOSEPH KENRICK</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 23, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chung Chan Funeral Home</u>		ADDRESS <u>2400 D.C.</u>		DATE <u>2-27-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2035 CERTIFICATE OF DEATH

Reg. Dist. No.

02048

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.	c. LENGTH OF STAY IN 1b 135 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1226 - 6th Street, N. W.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Inez Middle (none) Last Taylor		4. DATE OF DEATH Month February Day 26 Year 19 57	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 20, 1905
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) District of Columbia
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Charles Smith	
14. MOTHER'S MAIDEN NAME Mary Crowdy		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia - Bilateral 171X DUE TO pleural effusions Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Emphysema - severe secondary DUE TO To Carcinoma of Cervix with (c) metastases			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. ft. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 14, 1956 to February 26, 1957 , that I last saw the deceased alive on February 26, 1957 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Chester Z. Haverback M.D.		The Clinical Center National Institutes of Health	
PHYSICIAN'S NAME (Type) C Chester Z. Haverback, M.D.		Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 3-2-57	22c. NAME OF CEMETERY OR CREMATORY Woodlawn	22d. LOCATION (City, town, or county) (State) Washington DC
23. FUNERAL DIRECTOR'S SIGNATURE Travers's Funeral Home 389 R L Ave		24a. REC'D BY REGISTRAR MAR 1 1957	24b. REGISTRAR'S SIGNATURE Bened Thompson

CERTIFICATE OF DEATH

11

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		NEW YORK		NEW YORK		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
1000 BROADWAY		LABORER		HEART DISEASE		NATURAL		1957		NEW YORK		NEW YORK		NEW YORK	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
1957		NEW YORK		NEW YORK		NEW YORK		1957		NEW YORK		NEW YORK		NEW YORK	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
1957		NEW YORK		NEW YORK		NEW YORK		1957		NEW YORK		NEW YORK		NEW YORK	

BUREAU V. 3

MAR 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Block 22 Film G210 2-15-57 et

2036 CERTIFICATE OF DEATH

02049

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) a. STATE Virginia b. COUNTY Alexandria ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 38 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 83x-3 Alexandria			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 402 Hume Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Fred Middle Clifton Last Terrell				4. DATE OF DEATH Month February Day 5 Year 57					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH January 3, 1894			
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operating Engineer				10b. KIND OF BUSINESS OR INDUSTRY Powder Plant		11. BIRTHPLACE (State or foreign country) Texas			
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Luther Terrell				14. MOTHER'S MAIDEN NAME Rebecca Crenshaw					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give year or dates of service) WW I		16. SOCIAL SECURITY NO. 458-10-6637		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma, left lung 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) adenocarcinoma, rectum metastatic to lung DUE TO (c) Probable carcinoma of prostate gland.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. 1. Month, 19 Day, 19 Year p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)		(State)			
21. I certify that I attended the deceased from December 29, 1956 to February 5, 1957 , that I last saw the deceased alive on February 5, 1957 , and that death occurred at 12:50 A.M. , from the causes and on the date stated above.									
ACTUAL SIGNATURE James R. Stabenau				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland					
PHYSICIAN'S NAME (Type) James R. Stabenau, M. D.				DATE SIGNED 2/5/56					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 2/7/57		22c. NAME OF CEMETERY OR CREMATORY Washington National Cemetery		22d. LOCATION (City, town, or county) Washington, D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers				ADDRESS 3072-12th St NW, Wash DC		24a. REC'D BY REGISTRAR FEB 11 1957			
24b. REGISTRAR'S SIGNATURE Bessie Thompson									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03519

CERTIFICATE OF DEATH

02050

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Alabama b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 440X-3 Birmingham	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 12 Montrose Circle	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Earl Middle Calvin Last Thorn		4. DATE OF DEATH Month February Day 6 Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 3, 1921
9. AGE (In years lost birthday) 35 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor (Investments)		10b. KIND OF BUSINESS OR INDUSTRY Insurance	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James M. Thorn		14. MOTHER'S MAIDEN NAME Bessie Cox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give branch and dates of service) WW II		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 204.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchopneumonia (c) Acute myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 3 days 1 week 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. s. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 15, 1957 , to February 6, 1957 , that I last saw the deceased alive on February 6, 1957 , and that death occurred at 11:40 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gurston Goldin M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Gurston. Goldin, M. D.		DATE SIGNED 2/6/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-7-57	
22c. NAME OF CEMETERY OR CREMATORY ELMWOOD		22d. LOCATION (City, town, or county) (State) BIRMINGHAM, ALA.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 1400 Chapin St NW		24a. REC'D BY REGISTRAR 2-8-57	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

CERTIFICATE OF DEATH

STATE OF NEW YORK

BUREAU V. S.

FEB 13 1957

RECEIVED

2037 CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 4 Mo</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville 16-15-2</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11104 Snodgrass Ave.</u>				d. STREET ADDRESS <u>7981 New Riggs Rd</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Rhea</u> Middle <u>Rebecca</u> Last <u>Topas</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/26-1902</u>	9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Great Britain</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Solomon Rosenbloom</u>				14. MOTHER'S MAIDEN NAME <u>Sola Zelde Shuklat</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>219-26-2201</u>			
				17. INFORMANT <u>Joseph Topas 7981 New Riggs Rd</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>199.1 Congestive failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Secondary anemia, malnutrition</u> DUE TO (c) <u>Carcinomatosis of abdomen</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 months</u> <u>7 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9/8</u> , 19 <u>56</u> , to <u>2/3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/2</u> , 19 <u>57</u> , and that death occurred at <u>8 a M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eino Magi</u>				M.D. <u>8401 University Lane 2/3/57</u>			
PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>				ADDRESS (Street, city or town, state) <u>Silver Spring, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/4-1956</u>		<u>Nat Mem Park</u>		<u>Falls Church Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>				ADDRESS <u>1001 1st St</u>		24a. REC'D BY REGISTRAR	
						24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	
				DATE <u>2/5 1957</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1927

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lloyd</u> Middle <u>Samuel</u> Last <u>Truax</u>				4. DATE OF DEATH Month <u>February</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-12-77</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>11</u> Hours <u></u> Min. <u></u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rail Road Brakeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pa.</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>American-USA</u>			
13. FATHER'S NAME <u>Samuel Truax</u> (TRUAX)				14. MOTHER'S MAIDEN NAME <u>Not Known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Patient's Record</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremic state</u> <u>603X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Renal Insufficiency</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>congestive heart failure</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>5 yrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May</u> , 19 <u>56</u> to <u>Feb 23</u> , 19 <u>57</u> that I last saw the deceased alive on <u>Feb 23</u> , 19 <u>57</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. H. Zerk</u> M.D.				DATE SIGNED <u>2-23-57</u>			
PHYSICIAN'S NAME (Type)				ADDRESS (Street, city or town, state)			
<u>Takoma Park, Md.</u>				<u>7701 Canellane</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/26/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARK HEIGHTS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BRUNSWICK, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Byrnes</u> ADDRESS <u>1300 N. St. NW</u>				24a. REC'D BY REGISTRAR <u>Feb 25 1957</u>			
<u>- Washington, D. C. -</u>				24b. REGISTRAR'S SIGNATURE <u>J. Nelson Duddy</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER		DATE OF MARRIAGE		PLACE OF MARRIAGE	
OCCUPATION		INDUSTRY		TRADE		PROFESSION		VOCATION		BUSINESS		ART		SCIENCE		LITERATURE	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		INSTITUTION		ACADEMY		SEMINARY		CONVENT		OTHER	
RELIGION		METHODIST		BAPTIST		CATHOLIC		LUTHERAN		PRESBYTERIAN		ANGELICAN		JEW		OTHER	
MANNER OF DEATH		NATURAL		SUICIDE		HOMICIDE		ACCIDENT		DISEASE		INJURY		POISON		OTHER	
CAUSE OF DEATH		HEART		LUNGS		LIVER		KIDNEYS		STOMACH		INTESTINES		BRAIN		OTHER	
DATE OF DEATH		FEB 25 1957		TIME OF DEATH		10:00 AM		PLACE OF DEATH		HOME		HOSPITAL		NURSING HOME		OTHER	
SIGNATURE OF PHYSICIAN		J. H. SMITH		DATE OF SIGNATURE		FEB 25 1957		PLACE OF SIGNATURE		HOSPITAL		HOME		NURSING HOME		OTHER	
SIGNATURE OF CORONER		J. H. SMITH		DATE OF SIGNATURE		FEB 25 1957		PLACE OF SIGNATURE		HOSPITAL		HOME		NURSING HOME		OTHER	
SIGNATURE OF WITNESS		J. H. SMITH		DATE OF SIGNATURE		FEB 25 1957		PLACE OF SIGNATURE		HOSPITAL		HOME		NURSING HOME		OTHER	

BUREAU V. 3

FEB 25 1957

RECEIVED

2038

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARGARET Elizabeth</u> First Middle Last		4. DATE OF DEATH <u>TRUCKS</u> Month <u>2</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5</u> 1-30-18
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Barnes</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET CLARK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Annette Johnson (niece)</u> Address <u>11260 Old Bladensburg Rd. S.E., Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>Marked generalized Arteriosclerosis</u> (c) <u>Multiple meningioma</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/12</u> , 19 <u>57</u> , to <u>2/9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 9</u> , 19 <u>57</u> , and that death occurred at <u>10:45</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Marion Bankhead</u> M.D.		ADDRESS (Street, city or town, state) <u>9241 Col. Blvd</u> DATE SIGNED <u>2/9/57</u>	
PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead</u>		<u>Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 12, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>8434 Georgia Ave. Spring</u>		24a. REC'D BY REGISTRAR <u>2-13-57</u>	24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02054

Reg. Dist. No.

2039

Item 9 Film G211 3-4-57 et

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown	
c. LENGTH OF STAY IN 1b 61 hours		d. STREET ADDRESS RFD #2 Seneca	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Turner Last Turner		4. DATE OF DEATH Month 2 Day 14 Year 57	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown-Approx.
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 5 Days 14 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Dist. of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Doc		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Son - 2212 - 12th Place NW - Wash D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO 916.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1st, 2nd, 3rd degree Burns over approximately 90% of body DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Clothes caught fire from kitchen stove	
20c. TIME OF INJURY Month, Day, Year 3:00 p.m. 2-11-57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Germantown-Mont. Co., Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 2-14-57	
EXAMINER'S NAME (Type) Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/21/57	22c. NAME OF CEMETERY OR CREMATORY Seneca	22d. LOCATION (City, town, or county) (State) Seneca, Md
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sharden - Rockville, Md		24a. REC'D BY REGISTRAR EB 25 1957	24b. REGISTRAR'S SIGNATURE Bessie Thompson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

FEB 25 1957

RECEIVED

Small child of 1 year
John J. Smith - deceased

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02055

2040 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 22 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland			d. STREET ADDRESS 1802 Bay St., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Clarence (nmn) TYLER			4. DATE OF DEATH Month Day Year February 28 19 57		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 July 1896	9. AGE (In years lost birthday) yrs. 60	IF UNDER 1 YEAR Months Days Hours Min. 19 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doorman (Garfinkle's Department Store)			10b. KIND OF BUSINESS OR INDUSTRY Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Joseph Tyler			14. MOTHER'S MAIDEN NAME Jennie Harlings		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service Yes WW-I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Official Navy Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma esophagus with metastasis 150x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH NINE MONTHS					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. 91. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I attended the deceased from 6 Feb. , 19 57 , to 28 Feb. , 19 57 , that I last saw the deceased alive on 28 Feb. , 19 57 , and that death occurred at 6:00A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED James E. McClenathan Lcdr M.D. U.S. Naval Hospital, Bethesda, Md. 2-28-57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) James E. McClenathan, LCDR, MC, USN U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4 March 1957		22c. NAME OF CEMETERY OR CREMATORY 1st Baptist Church Cemetery, Amherst, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.E. Jarvis, 1432 U St., NW, Washington, D. C.			24a. REC'D BY REGISTRAR DATE 2-28-57		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Reg. No. 100-1000

7-1-57

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

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BUREAU V. S.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02056 *214*

Reg. Dist. No.

2041

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			c. LENGTH OF STAY IN 1b 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2</i> Kensington		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9701 Conn. Ave.				d. STREET ADDRESS 9701 Conn. Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM O. VARN				4. DATE OF DEATH Month Day Year Feb. 3, 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 18, 1907	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 2 Days 15		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newspaper Treas. Nat'l.				10b. KIND OF BUSINESS OR INDUSTRY Assoc. Press		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME (Press Club) William H. Varn				14. MOTHER'S MAIDEN NAME Lula Catherine Oxner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 057-10-2780		17. INFORMANT Louise Varn-wife		Address Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion <div style="margin-top: 10px;"> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) </div> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH Sudden </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Feb. 3, 1957	
EXAMINER'S NAME (Type) Frank J. Broschart,							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 6, 1957		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner C. Humphreys</i>				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE <i>7/57</i>	
24b. REGISTRAR'S SIGNATURE <i>Frances Teller</i>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased William A. Verrill		Sex Male	
Date of Birth Nov. 18, 1907		Race White	
Place of Birth South Carolina		Occupation Newspaper Editor	
Usual Residence 1001 Comm. Ave.		Where Found 1001 Comm. Ave.	
Cause of Death Coronary Occlusion		Manner of Death Natural	
Signature of Medical Examiner [Signature]		Signature of Coroner [Signature]	

BUREAU A. T.

FEB 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02057

2042

CERTIFICATE OF DEATH

Reg. Dist. No.

764

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11717 Highview Ave.		d. STREET ADDRESS 11717 Highview Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Carrie Etta Middle Varney Last		4. DATE OF DEATH Month February Day 4 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/21/61
9. AGE (In years last birthday) 95 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lebanon, Maine		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Alexander Corson		14. MOTHER'S MAIDEN NAME Mary E. Tibbetts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Helen Varney 11717 Highview Ave. S.S.Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebrovascular Renal Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 Days 5 Yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 3 , 1957, to Feb 4 , 1957, that I last saw the deceased alive on Feb 3 , 1957, and that death occurred at 8 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Harold Heiger		ADDRESS (Street, city or town, state) 1835 Eycost NW	
PHYSICIAN'S NAME (Type) Harold Heiger MD		DATE SIGNED 2/4/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 2/5/57	
22c. NAME OF CEMETERY OR CREMATORY Cold Spring Cemetery		22d. LOCATION (City, town, or county) (State) East Rochester, New Hampshire	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington, D.C.		24a. REC'D BY REGISTRAR FEB 6 1957	
24b. REGISTRAR'S SIGNATURE Frances Patten			

BUREAU V. S.

FEB 6 1957

RECEIVED

2043

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 13 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8003 EASTERN AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MABEL Middle CELIA Last VAUGHAN		4. DATE OF DEATH Month FEB. Day 25 Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/1/72
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER - OWN HOME		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RAYNOR F. BARHAM		14. MOTHER'S MAIDEN NAME REBECCA T. JUDKINS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Address Mrs. Ruth V. Keefe, 8003 Eastern Ave., Apt. 304 Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 1952 , to Feb 25 , 1957, that I last saw the deceased alive on Feb 24 , 1957, and that death occurred at 7¹⁵ A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 900 17th St N.W. DATE SIGNED Lawrence J. Thomas ACTUAL SIGNATURE Lawrence J. Thomas M.D. PHYSICIAN'S NAME (Type) LAWRENCE J. THOMAS			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/27/57	
22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner G. Humphrey ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR 2/28/57 24b. REGISTRAR'S SIGNATURE Frances Patton	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02059

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. LENGTH OF STAY IN lb 7 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9604 MT. PISGAH ROAD				d. STREET ADDRESS 9604 MT. PISGAH ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First JOHN Middle ANDREW Last WAITE				4. DATE OF DEATH Month FEB. Day 11 Year 1957				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/9/77		
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 79 Days 79		IF UNDER 24 HRS. Hours 79 Min. 79				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - retired			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Waite				14. MOTHER'S MAIDEN NAME unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 028-10-3665		17. INFORMANT Mr. Don A. Waite, 9604 Mt. Pisgah Road Silver Spring, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) FRANK J. BROSCHART				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/13/57		22c. NAME OF CEMETERY OR CREMATORY Wash. Nat'l. Cemetery		22d. LOCATION (City, town, or county) (State) Prince George County, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE 7/16/57		
				24b. REGISTRAR'S SIGNATURE Frances Lott				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

FEB 19 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02060

2045
CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <u>Montg</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown Rural</u>		c. LENGTH OF STAY IN 1b <u>22 Yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Germantown Rural</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>	
d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Horace</u> Last <u>Wear</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>17</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 2-1901</u>
9. AGE (In years last birthday) <u>55 yrs.</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>15</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Repairman.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Petersburg Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Joseph J Wear</u>		14. MOTHER'S MAIDEN NAME <u>Emma C. Wood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u>577-09-1086</u>	
17. INFORMANT <u>Margaret E. Wear.</u>		Address <u>Germantown. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 24, 1956</u> , to <u>February 17, 1957</u> , that I last saw the deceased alive on <u>February 10, 1957</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.		DATE SIGNED <u>5/1/85</u>	
ACTUAL SIGNATURE <u>James P. Kerr</u>		ADDRESS (Street, city or town, state) <u>Lanham, Md.</u>	
PHYSICIAN'S NAME (Type) <u>James P. Kerr</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-19-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Park Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner, Gaithersburg. Md.</u>		24a. REC'D BY REGISTRAR <u>2-19-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Abner L. Cook</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Usual residence		7. Date of death		8. Place of death		9. Cause of death		10. Manner of death		11. Signature of physician		12. Signature of registrar	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairland Nursing Home</u>		c. LENGTH OF STAY IN 1b <u>2 wks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X 2 Chevy Chase</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R-2 Silver Spring</u>				d. STREET ADDRESS <u>6802 Georgia St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Ellen</u> Last <u>Wood</u>				4. DATE OF DEATH Month <u>2</u> Day <u>8</u> Year <u>57</u> 19			
5. SEX <u>fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-12-62</u>	
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Va</u>	
13. FATHER'S NAME <u>Wesley Wood</u>				14. MOTHER'S MAIDEN NAME <u>Mildred Ann Cropp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Nursing Home Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac failure</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocarditis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u> <u>4 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Feb. 11, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Orlean Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Orlean, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>				24a. REC'D BY REGISTRAR <u>2901 11th St. N.W.</u> ADDRESS <u>Washington 9, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>FEB 13 1957</u> DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02062

2047

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Alabama</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>44X-3 Vredenburgh</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		d. STREET ADDRESS <u>None</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>Beatrice</u> Last <u>Young</u>		4. DATE OF DEATH Month <u>February</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>31 December 1931</u>
9. AGE (In years last birthday) <u>25</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>21</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dush Albert Threadgill</u>		14. MOTHER'S MAIDEN NAME <u>Leota Maness</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>19-38-9827</u>	
17. INFORMANT <u>The Medical Record, Clinical Center</u> <u>National Institutes of Health, Bethesda 14, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> <u>754.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARDIAC SURGERY</u> DUE TO (c) <u>VENTRICULAR SEPTAL DEFECT</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8</u> <u>4 days</u> <u>25 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Renal Failure, CNS Damage, Thrombocytopenia</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. ft.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10 February, 1957</u> , to <u>22 February, 1957</u> , that I last saw the deceased alive on <u>22 February, 1957</u> , and that death occurred at <u>2:14 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodore Cooper</u>		ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Theodore Cooper, M. D.</u>		DATE SIGNED <u>2/23/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur. Transit 2/23/57</u>		22b. DATE THEREOF <u>2/23/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Tunnel Springs Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Monroeville, Alabama</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>2-23-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
OCCUPATION		SEX	
CAUSE OF DEATH		MANNER OF DEATH	
DATE OF BIRTH		PLACE OF BIRTH	
FATHER'S NAME		MOTHER'S NAME	
EDUCATION		RELIGION	
MARRIAGE		PREVIOUS DEATHS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		PLACE OF SIGNATURE	

BUREAU V. S.

FEB 28 1957

RECEIVED

2048

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRESTVIEW-</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRESTVIEW</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4902 CRESCENT</u>		d. STREET ADDRESS <u>14902 CRESCENT</u>	
3. NAME OF DECEASED (Type or print) First <u>PAUL</u> Middle <u>C.</u> Last <u>ZIEHL</u>		4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 2 1882</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>QUARTERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OIL LIST Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Edward Ziehl</u>		14. MOTHER'S MAIDEN NAME <u>Thelma Zammucht</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MARY ANN ZIEHL</u>		Address <u>4902 CRESCENT</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease -</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 one year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1953</u> , 19____, to <u>February-2 1957</u> , that I last saw the deceased alive on <u>February 1</u> , 1957, and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>22-1587 DATE SIGNED</u>			
ACTUAL SIGNATURE <u>Irene G. Tamagna</u> M.D. <u>7101 CONNECTICUT AVE CHCH., 15th</u>			
PHYSICIAN'S NAME (Type) <u>IRENE G. TAMAGNA</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>FEB. 5 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>SUITLAND, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don DeVol</u>		ADDRESS <u>2224 WIS AVE. D.C.</u>	24a. REC'D BY REGISTRAR <u>2-5-57</u>
		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 2 1957

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